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Senate

The Senate met at 10 a.m. and was called to order by the Honorable JEFF MERKLEY, a Senator from the State of Oregon.

PRAYER

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

Let us pray.

Gracious God, through the power of Your spirit, empower us to live vibrant lives that glorify You. Awaken our lawmakers to the opportunities all around them. Help them to hear Your call to move forward and to accomplish the things that honor You, as You guide them in the pursuit of wisdom and truth. May they confidently face their duties, knowing that You are their sufficient shield and defense. Lord, make them willing to listen, even to people with whom they expect to differ, united by the desire to represent You with exemplary conduct.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JEFF MERKLEY led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 11, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JEFF MERKLEY, a Senator from the State of Oregon, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

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

NOTICE

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

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

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

Senators' statements should also be formatted according to the instructions at http://webster/secretary/cong__record.pdf, 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.

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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.

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RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will be in a period of morning business. Senators will be permitted to speak for 10 minutes each during that period. Republicans will control the first 30 minutes, and the majority will control the next 30 minutes. We will continue work on an agreement to vote in relation to the drug reimportation matter, the Crapo motion to commit, and the side-by-side to the Crapo motion. These amendments and the motion are with respect to H.R. 3590, the health insurance reform legislation.

Yesterday, we filed cloture on the bill we got from the House, the appropriations bill, H.R. 3288, which includes Commerce-Justice-Science, Military Construction, Labor-HHS, Transportation, financial services, State and Foreign Operations. We are going to have at least two rollcall votes on motions to waive with respect to the appropriations conference report today. Senators will be notified when these votes are scheduled.

I direct this question through the Chair to my friend from South Dakota. I offered a unanimous consent request yesterday evening that set up a schedule of votes on the Crapo motion and, of course, the Dorgan amendment. Last night, I was told the Republicans were not ready yet. I ask my friend, are the Republicans ready to vote?

Mr. THUNE. Mr. President, the Republican leader has just arrived. I reserve any statement for him.

Mr. REID. I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE AND THE OMNIBUS

Mr. MCCONNELL. Mr. President, Republicans are fully engaged in the health care debate. It is our view that there is no more important work we can do here than to show Americans what the Democratic plan for health care would mean to them. Once we return to the debate, Republicans will be ready with two important amendments.

One of those amendments, by Senator CRAPO, would enable the President to keep one of the pledges he made as a candidate and as President about what the Democratic plan for health care reform would look like. He said that no family making less than $250,000 a year and no individual making less than $200,000 a year would see a tax increase of any kind. The Crapo motion would ensure that promise is kept.

An amendment by Senators HUTCHISON and THUNE would ensure that none of the taxes imposed by this bill would go into effect a day earlier than the benefits. In other words, you don't get taxes before you get benefits. This is a commonsense amendment. You certainly wouldn't ask someone to pay for the mortgage on a house 4 years before they were allowed to move in. In the same way, we should not tax people for a benefit they don't get for 4 long years.

The Hutchison-Thune amendment also aims to keep government honest, because most Americans have a hard time believing Washington would collect taxes on one thing for 4 years and actually have the discipline not to use the money on something else. This amendment would guard against that.

For the moment, the majority has decided to take us off health care. It has moved to an Omnibus appropriations bill that has all the hallmarks of all the other bloated spending bills we have seen this year. It is really outrageous, actually. At a time of double-digit unemployment, at a time when Democrats are talking about increasing by nearly $2 trillion the amount of money the government is legally allowed to borrow, the majority has moved us off of one $2.5 trillion spending bill and on to a 1,000-page omnibus that would cost the American taxpayer another $½ trillion right in the middle of a recession.

Once again, the majority has shown a lack of restraint when it comes to spending. At a moment of record debt, at a moment when inflation is nearly flat, this bill represents a 12-percent annual increase in government spending. Let me say that again. Inflation is flat. Yet we are increasing discretionary spending by 12 percent in this omnibus spending bill. The American people are not increasing their spending 12 percent. Moreover, it includes a number of controversial, unrelated provisions, including, among other things, language to weaken restrictions on abortion funding.

This $½ trillion spending bill spends $50 billion more than last year. All this spending comes right on the heels of a new report from Treasury that says the government ran a deficit of nearly $300 billion in October and November—the worst deficit we have ever had at this point in a fiscal year, ever. At a time when families across the country are struggling to make ends meet, lawmakers almost seem to be flouting their ability to spend taxpayer money. This bill contains many worthy projects. Unfortunately, the majority has piled on so much spending, so much debt and new controversial policies that I certainly can't support it.

As you may know, the Senate is considering a bill that would make basic changes in the country's health care system. We have been debating it for weeks. What I keep hearing on the other side is no reference to what the American people think. I hear these arguments about making history. Ignoring the public is not a great way to make history. We have not seen poll data for months that indicate the American people support the Reid bill. The most devastating one came out last night. A CNN opinion research poll taken December 2 and 3, this week—not exactly a bastion of conservatism—indicates that 61 percent of the American people oppose this health care bill and only 36 percent favor it.

We are looking for one courageous Member of the other side of the aisle—just one—to stand up and say he or she will not ignore the overwhelming opinion of the American people, he or she will not be so arrogant as to assume we have the right answer here and 61 percent of the American people somehow don't know what they are talking about.

The American people are pretty smart. They have been watching this carefully. This health care bill, like no other issue, affects every single American regardless of age. Everybody is interested in the subject. They have watched the debate closely. They are telling us: Please, Congress, please do not pass this bill.

I yield the floor.

RESERVATION OF LEADER TIME

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

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period of morning business, with Senators permitted to speak for up to 10 minutes each, with the Republicans controlling the first 30 minutes and the majority controlling the next 30 minutes.

The Senator from Texas.

ORDER OF PROCEDURE

Mrs. HUTCHISON. Mr. President, as I understand it, we are now in the 30-minute timeframe for the Republicans; is that correct?

The ACTING PRESIDENT pro tempore. That is correct.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that we be allowed to have a colloquy so we can go back and forth.

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

Mrs. HUTCHISON. I thank the Acting President pro tempore.

HEALTH CARE REFORM

Mrs. HUTCHISON. Mr. President, I think the Republican leader just stated the case for why it is so important that we have the votes and that we go back to the drawing board on this bill. Americans are looking at the fine print of this bill. They are seeing $½ trillion in taxes.

Just this week, the President has had a jobs summit because we are all concerned about jobs. My goodness, since the President took the oath of office, more than 3.5 million Americans have lost their jobs—300,000 Texans—our budget has tripled to $1.4 trillion, and the Federal debt as a portion of the U.S. economy has risen to its highest level since World War II. So we are very concerned about these taxes. In fact, the small businesses of our country have said: No, do not do this to us.

The NFIB, which is the National Federation of Independent Business, sent a letter just this week saying:

> 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?

Well, the answer to the first question is clearly no because the business taxes start on January 1, 2010—3 weeks or so from now—and going forward, the mandates and taxes in 2014 to small business are egregious. It could be $750 per employee or it could be $3,000 per employee if you do not have exactly the right mix of health care coverage for your employees. Well, at $3,000 per employee, small businesses are telling me: I am out of here. We are just going to let people go to the government option because we cannot afford that.

So the answer to question No. 2 in the NFIB letter—which is, ''Will the bill increase the overall cost of doing business?''—is, well, of course it will, at a time when we are seeing the numbers of people employed go down.

We are in a financial crisis in this country. People are jobless. We are in a holiday season. People are very stressed, and here we have a health care bill being rushed through, without amendments being able to come forward with a real chance for passing them. The cost of business is going to go up, which means more people are going to be laid off.

Now, I want to ask my friend, the Senator from South Dakota, a question because he and I are teaming up on an amendment. If we are going to have taxes increase in 3 weeks, you would say: Oh, OK, well taxes are going to start in 3 weeks, so, then, where is the package I signed up for that is going to lower my health care costs? So I would ask the Senator from South Dakota, when do the programs that are supposed to lower health care costs take effect?

Mr. THUNE. I would say to my friend from Texas, Senator HUTCHISON, that as we have examined this legislation and have looked at its cost and its benefits and how that is distributed over time, it has become clear that what the other side has tried to do—the Democrats have tried to do—with this bill is understate its true cost by front-loading the tax increases and back-loading the spending. In other words, the tax increases kick in right away, when much of the benefit of the bill does not kick in for several years.

So I want to point something out, just to illustrate what the Senator from Texas has said; that is, the tax increases in the bill begin on January 1 of this year. So 21 days from now, Americans, individuals, families, and small businesses are going to see their taxes go up. Unfortunately, they are not going to see any benefit come until 1,482 days later.

What that, in effect, does is it understates the total cost of this legislation. They have said: We want to get this under $1 trillion. The President said: I need a bill under $1 trillion. So they have tried to come up with a bill that is about $1 trillion. But what they do not tell you is that by delaying the benefits and front-loading the tax increases, you are actually going to have a 4- or 5-year period where people are having to experience tax increases. That is going to impact the small businesses because you have a Medicare payroll tax increase, which, by the way, for the first time, will not be used for Medicare but will be used to create a whole new entitlement health care program.

You have an employer mandate which is going to hit small businesses. You have the tax on medical device manufacturers, on prescription drugs, on health plans. You have all these taxes that kick in right away.

So what happens? These taxes get passed on to the consumers in this country in the form of higher premiums, so people are going to see their premiums go up. Small businesses are going to see their taxes go up immediately—well, 21 days from now. But Americans are not going to see any benefit from this for 1,482 days. So what we have is a gimmick that has been used to disguise the total cost of this bill, which we all know when fully implemented is not $1 trillion but $2.5 trillion.

So the Senator from Texas and I have a motion, which I believe is supported by the Senator from Wyoming, who is in the Chamber, that would delay the tax increases until such time as the benefits begin so we synchronize or align the tax increases and the fees to begin at the same time the benefits do so we will reflect the true cost of this legislation to the American people and not unfairly begin punishing small businesses by raising their taxes before a single dollar of benefit is going to be distributed to the American people.

Mrs. HUTCHISON. So I would ask the Senator from South Dakota—because it is our amendment, the Hutchison-Thune amendment—and surely the American people, who would look at the debate, would say: We are missing something. This cannot be right. We can't have taxes that are increasing our premiums, increasing our prescription drug costs, increasing our medical devices we must have for our health care for 4 years. Did he say that right? Did he say we would be paying those higher costs for 4 years before there is any option available to allow more people to have health care coverage?

Mr. THUNE. I would say to my friend from Texas, it is kind of the same old Washington game, the same old Washington gimmick, the same old backroom deal that has been cut basically that, of course, we have had no input into. Incidentally, there is another now, the latest permutation of this discussion, going on right now behind closed doors, which is the Medicare expansion, which is a subject for a whole other day.

But I think the American people are looking at this and saying: How does this impact me? More than anything else, they are watching this big debate in Washington, DC, and saying: How does this impact me? I think what they are concluding is that 90 percent of the American public, according to the Congressional Budget Office, would see their premiums stay the same at best or at worst go up, and when I say ''stay the same,'' that means double the rate of inflation annual increases in their health insurance premiums.

So the best you can hope for, if you are an American today, is the status quo when it comes to your health insurance premiums.

If you buy in the individual marketplace, your premiums are going to go up 10 to 13 percent above the annual, double the rate of inflation increases that we are currently seeing.

So that is what happens to the American public, the average person out there, in terms of their health insurance premiums. If you are a small business, you are looking at tax increases. You are looking at a whole new raft of tax increases that you are going to end up having to pay, which is why all of the small business organizations—the Senator from Texas pointed out the letter from the National Federation of Independent Business, which says this is going to drive the cost of doing business up. This is going to increase the cost of health care, not lower it. What they want to see in reform—small businesses that are the economic engine that creates jobs in this economy—is they want to see health care reforms put in place that drive health care costs down.

We know from every estimate that has been done, such as from the Congressional Budget Office—we have some data now from the CMS actuary that just came out yesterday that says overall health care expenditures are

going to go up, health insurance premiums are going to go up. So small businesses are looking at higher taxes.

If you are a senior citizen in America, and one of the 11 million people who get Medicare Advantage, your benefits are going to be cut. So you have higher premiums, increased taxes on small businesses, Medicare benefit cuts to senior citizens across this country, and cuts to providers, and if you are a young American, you are faced with a $2.5 trillion new entitlement program that you are going to have to pay for.

That is what the American people, as they are observing this debate, can expect to come out of this, if the bill that has been proposed by the majority is enacted. That is why we are working so hard to defeat that and put in place some commonsense reforms that actually make sense to the American people.

I know the Senator from Wyoming, who is a physician, knows full well the impact of many of these policies from being on the front line. He is someone who has had to deliver health care services in a rural State. So I would ask him to give us his thoughts about what these tax increases and Medicare cuts are going to mean to health care delivery in places such as Wyoming.

Mr. BARRASSO. I thank my colleague from South Dakota because South Dakota and Wyoming are very similar in many ways. Both have rural areas all spread across the State, with people needing health care.

And I have seen it. I have seen the concerns from people, but also from small businesses. My colleagues mentioned the National Federation of Independent Business. A lot of businesses in Wyoming are members of that organization, and rightfully so, because small business is the engine that drives the economy. They are the job creators in this country.

I see these taxes—4 years of taxes—before the first health care services are given as going to hurt our small businesses in Wyoming. It is going to hurt small businesses all around the country.

In one of the morning papers, it talks about the plans that are being presented by the Democrats, with all the increases in health costs—the fines, the taxes, that this will cost 1.6 million jobs before the first health care services are given in 2013—1.6 million jobs across the country. That affects all of our States.

At a time when unemployment is at 10 percent, at a time when Investor's Business Daily, this morning, says: ''Job Cuts Hit Hardest on Low-Skill Men; Outlook Is Gloomy,'' at a time when we are looking at an outlook which they call in the headlines of the front page of their paper ''gloomy,'' why would we say: Lets increase taxes on Americans, and then cut Medicare from our seniors who depend upon Medicare, and lets not improve services for 4 more years?

It is no surprise then that the Republican leader would come to the floor and say we have now reached an all-time high of American people opposed, completely opposed, to this piece of legislation. The Republican leader read a poll that said 61 percent of Americans now oppose this bill. Well, it is because they are learning more about it. The more people of America see what is in this bill, the more they realize they cannot believe any of the promises that were made by the Democrats, by the administration, the promises that were made, and the polling shows it.

Two specific questions that were asked in the poll were two specific promises that the President made. One is, he said he will not sign a bill if it adds one dime to the deficit. OK. We do not want to add to the deficit, although the Democrats want us to vote this weekend on raising the debt level by well over $1 trillion. And why? Because they cannot control the spending. But the question was, do you think the Federal budget deficit would or would not increase if this bill is passed—when the President said it will not raise it by a dime?

Mr. President, 79 percent of Americans said this is going to increase the deficit. Only 19 percent believe what the President is telling the American people.

Then the question of taxes. The President said: My plan will not raise your taxes one penny. What do the American people think when the President speaks? Question: Do you think your taxes would or would not increase? This is the CNN poll the Republican leader just talked about, done earlier this month: Do you think your taxes would or would not increase? The number of people who believe their taxes will increase if this passes, 85 percent. Eighty-five percent of the American people believe they are not getting it straight from the President of the United States. Only 14 percent believe him when he says he will not raise taxes a penny.

So we have the Democrats bringing forth a bill—to me, as a practicing physician in Wyoming, taking care of families in Wyoming, talking to doctors, talking to patients, having townhall meetings in the State, having telephone townhall meetings, the Democrats bring forth a bill that the people of Wyoming and the people of America realize is going to cost them more, is going to add to the deficit, and hurt the health care they receive.

Eighty-five percent of Americans are happy with the health care they receive. They do not like the cost. They do not like the price. But this bill we are looking at is going to raise premiums for people who have insurance. The President promised that for families all across America, their premiums would drop by $2,500 per family. But if you go out there trying to buy insurance, if this bill passes, you are going to end up paying $2,100 more than you would otherwise if nothing passes. That is why the majority of Americans say we would be better off if nothing passed. That is what the American people say. The Democrats seem to be ignoring the voice of the American people. At a time of 10 percent unemployment, at a time when the National Federation of Independent Business points out that we will lose over a million more jobs if this passes, we should be looking at ways to help small businesses hire more workers, hire more people.

The small businesses continue to be the engines that drive up the economy. Senator COLLINS from Maine was on the floor and gave an explanation of some of the taxes on all of the small businesses in Maine. If you have 10 employees and you go to an 11th employee, if this bill passes, that small business gets penalized for growing their business.

We want to have an opportunity to hire people.

She also explained that if we actually try to work ways through small businesses to give raises to people, those businesses get penalized from a tax standpoint.

As I look at this health care bill, we need health care reform that is going to bring down the cost of care. This bill is going to raise the cost of care for all Americans. It is going to hurt our seniors by taking almost $500 billion out of Medicare, a program on which the seniors depend. It is going to raise $500 billion in taxes which is going to hurt the engine that drives the economy. It is going to hurt small business. It is going to cause people to lose their jobs. I think it is foolish for people to continue to support this bill. It makes no sense.

I listened to my colleague from South Dakota who showed the chart that says 21 days until the tax increases begin but almost 4 years until the benefits begin. What do the people in South Dakota have to say about this?

Mr. THUNE. Let me, if I might, enter into a discussion with the Senator from Wyoming because, as he said, his State and my State are not unlike in terms of the composition of population. We have big geographies in Wyoming and in South Dakota and in the West and a lot of rural health care delivery. The primary job creator in places such as Wyoming and South Dakota is small business. Small businesses are the economic engine that creates jobs.

As the Senator from Wyoming mentioned, according to many of the analyses that have been done of this legislation, it would be a job killer. It has been suggested by the National Federation of Independent Business that 1.6 million jobs would be lost.

What is ironic about that is I have heard our colleagues on the other side repeatedly say this is going to be great for jobs. This is going to be good for the economy. If that is true, then why are all of these business organizations coming out and saying it would increase the cost of doing business and it would increase health care costs? We

have that now validated by the Congressional Budget Office, by the CMS Chief Actuary at Health and Human Services saying overall health care costs under this legislation are going to go up, not down, both as a percentage of the gross domestic product as well as for individuals who are going to see it in the form of higher health insurance premiums.

I say to my friend from Wyoming, because he and I represent similar constituencies and the economies are similar, although he has—we wish we had more oil and gas in South Dakota along the lines of what they have in Wyoming—but the small business sector is what creates jobs.

He mentioned the National Federation of Independent Business. I wish to mention one other letter we received from an organization called the Small Business Coalition for Affordable Health Care. In it they state that these reforms fall short of long-term, meaningful relief for small business. Any potential savings from these reforms are more than outweighed by the new taxes, new mandates, and expensive new government programs included in the bill. This is signed by 50 small business organizations, one of which, by the way, is the American Farm Bureau Association, which is a big presence in my State, represents a lot of farmers and ranchers, small business people, and I am sure represents a lot of members in the State of Wyoming as well as in the State of Texas.

I think what they are saying is, what all of these business groups are saying, and that is we don't find anything in this—there may be some good things in it, but we find the overall core elements of this bill to be a detriment to job creation, will kill jobs, and will drive up the cost of doing business in this country.

It is hard for me to believe that some of the statements made by the other side—and I assume they are making them with the greatest sincerity, but they are factually wrong. If they weren't, we wouldn't have every business organization in this country coming out and saying we are opposed to this because it is going to increase the cost of doing business, it is going to kill jobs, and it is going to increase the cost of health care.

So to our colleague from Texas I would say I suspect she has a lot of small businesses in her State, not unlike Wyoming and South Dakota, that share that view.

Mrs. HUTCHISON. Mr. President, I am glad you mentioned the Farm Bureau because my constituents in the Farm Bureau, 400,000 members of the Texas Farm Bureau, have contacted me repeatedly about how bad this will be for the farmers, the small businesses they own, and the few people they employ. Maybe they have five employees. This will be a killer for them.

To reinforce the letter that the Senator from South Dakota read from the Small Business Coalition for Affordable Health Care, they say in the letter:

> If this bill is enacted, the small business community will be forced to divert resources away from hiring and expansion, the very investments our country so desperately needs as it continues to struggle in a faltering economy with double-digit unemployment.

Then they go on to talk about what those costs are going to be: a small business health insurance tax; an employer mandate that encourages job cuts, not job creation; and the temporary small business tax credit falls short.

I am glad they mentioned this temporary small business tax credit because I have heard them say on the other side of the aisle: But there is a tax credit for small business that will alleviate the pain.

Well, that credit is for employers with fewer than 25 employees with average annual wages of less than $40,000. Very few small businesses are going to be able to qualify for this tax credit. That is a very strict standard. The average annual wages of less than $40,000 are going to be very difficult. However, if they qualify, the credit is temporary. The credit is temporary. It is not a permanent credit that helps people who would be able to qualify for this credit. So, in effect, this is not a tax credit at all, and certainly when it goes away it will help no one.

I ask unanimous consent to have printed in the RECORD the letter from the Small Business Coalition for Affordable Healthcare.

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

DECEMBER 10, 2009.

DEAR REPRESENTATIVE: Representing the country's largest, oldest and most respected small business associations who have spent more than a decade working to increase access and affordability of private health insurance, the Small Business Coalition for Affordable Healthcare is writing to express our opposition to the Patient Protection and Affordable Care Act (H.R. 3590).

Small business has been a constructive participant in the current healthcare debate. Our small business and self-employed entrepreneurs have been clear about what they need and want: lower costs, more choices and greater competition for private insurance. These reforms are critical, but to be workable and sustainable, they must be balanced against the overall cost of doing business. Unfortunately, with its new taxes, mandates, growth in government programs and overall price tag, the Patient Protection and Affordable Care Act costs too much and delivers too little.

While a few of the provisions in the bill reflect some of the insurance market reforms that the small business and self-employed communities have long sought, those reforms fall short of long-term meaningful relief for small business. Any potential savings from those reforms are more than outweighed by the new taxes, new mandates and expensive new government programs included in the bill. Those new costs of doing business are also disproportionately targeted at small business. If this bill is enacted, the small business community will be forced to divert resources away from hiring and expansion—the very investments our country so desperately needs as it continues to struggle in a faltering economy with double-digit unemployment. Those new costs include:

A small business health insurance tax

Though small business has repeatedly called for reducing the cost of health insurance, the Senate bill includes a devastating new $6.7 billion annual tax ($60.7 billion over ten years) that will fall almost exclusively on small business and the self-employed because they purchase in the fully-insured market. While the fee is levied on the insurance company, a recent CBO report confirms the small business insurance tax ''would be largely passed through to consumers in the form of higher premiums for private coverage.'' This will send costs upward—the opposite of what the nation's small employers need.

An employer mandate that encourages job cuts, not job creation

The only certainty of an employer mandate is that it punishes both the employer and employee. The employer bears the first blow in trying to afford the new unfunded mandate and the second blow is borne by the employee in the form of lower wages and job loss. The mandate in H.R. 3590 devastates the small business community in two ways. First, since the bill does little to make insurance more affordable and the tax credit is so limited, few will be able to obtain affordable insurance. Second, the penalties assessed on firms—both offering and non-offering—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. Overall, the mandate included in this legislation is especially troubling because it fails to recognize how the cost of health benefits directly impacts wages of the employee. Instead, H.R. 3590 blames the employer for a cost (health insurance) that is beyond their control.

The temporary small business tax credit falls short

A short-term tax credit only puts off the inevitable—increased cost in future years. The effectiveness of the tax credit in H.R. 3590 is limited: the full value of the credit is only available to those with wages of less than $20,000 and phases out at $40,000. While the credit is designed to offset the cost of insurance, its ''savings'' potential is merely temporary since it only applies if you buy insurance in the exchange and it expires after just two years.

Health insurance exchange plans lack affordable choices

Small business has long sought a simpler and more efficient way to shop for insurance. H.R. 3590 creates a framework for exchanges that can help ease administrative and overhead costs. However, those savings are quickly erased if the exchange plans are more expensive than what small employers can afford. A recent CBO analysis of premiums under H.R. 3590 paints a disheartening picture: small group premiums, at best, would decrease by about 2 percent and could increase 1 percent. The impact on non-group premiums is even more devastating, as they are expected to increase an average of 10–13 percent per person. Those estimates, in addition to the financing provisions included in the bill, slam the 'savings' door shut. Steps must be taken to ensure that a greater variety of more affordable plans are available to small employers and their employees.

Limited value of Simple cafeteria plans

The inclusion of Simple cafeteria plans in H.R. 3590 has the potential to bring about a new option for small employers seeking to offer coverage in an employer-sponsored setting. The bill, however, currently lacks language to permit owners of many ''pass-

through'' business entities to participate in cafeteria plans. Unless owners can participate in the plan, they will be less likely to provide insurance to their workforce.

Insurance rating reforms that result in ''rate shock''

Employers in the small group and non-group market have long lived with the fear that a single illness could either price them out of affordable insurance or that they could be rejected for coverage altogether. While H.R. 3590 attempts to ensure that insurance will be more widely available to all, the restrictive rating (3:1 on age) and lack of a phase-in for existing plans threatens to undermine the viability of both plans that people own today or plans that they will buy in the future through the exchange. Only balanced rating reforms that are phased-in over an appropriate timeframe have the potential to transform these poorly functioning insurance markets.

New paperwork burdens and costs for small businesses

The Patient Protection and Affordable Care Act imposes a new tax-compliance paperwork burden on small businesses. The ''corporate reporting'' provision is an expansion of reporting requirements (for transactions of more than $600), which adds another $17 billion to the cost of doing business for small business.

A waiting period that lacks flexibility

Small employers, including those who employ full-time, part-time, temporary and seasonal workers, face much higher turnover rates than their large business counterparts. They face significant challenges related to providing healthcare benefits to their workforces. The Patient Protection and Affordable Care Act presents two specific problems. First, it defines a full-time employee as working an average workweek of 30 hours. Second, it outlines a 90-day waiting period, but then implements fines (at the 30–60-day and the 60–90-day timeframe) of $400 and $600 per affected worker respectively. In industries with above average turnover (e.g. the restaurant industry has roughly a 75 percent turnover rate annually) these provisions would lead to fewer full-time workers and less hiring overall.

Employers and employees lose flexibility and choice

Small employers need more affordable health insurance options. However, the prohibition of HSA, FSA and HRA funds to purchase over-the-counter medications, along with the $2,500 limit on FSA contributions, diminishes flexibility and threatens to further limit the ever-shrinking options employers have to provide meaningful healthcare to their employees.

An unprecedented increase in the Medicare payroll tax

Since its creation the payroll taxes dedicated to Medicare programs have been dedicated specifically to funding Medicare. However, the Patient Protection and Affordable Care Act changes the purpose of the tax while setting the precedent to use payroll taxes to pay for other non-Medicare programs. Furthermore, it will raise taxes for some small businesses.

No meaningful liability reform

Our medical liability litigation system creates a disincentive for affordability and efficiency while creating a climate where the practice of defensive medicine increases healthcare spending, and overall costs. Those increased costs extract a particularly heavy toll on the ability of small business to access affordable healthcare for their employees and dependents. Meaningful liability reform will inject more fairness into the medical malpractice legal system, and reduce unnecessary litigation and legal costs.

A public option that threatens choice and competition

A government-run plan cannot compete fairly with the private market and threatens to destroy the marketplace, further limiting choices. We believe that, with proper reforms, the private market can be held accountable and provide greater competition and lower-cost solutions where insurers compete based on their ability to manage, rather than shed risk.

While our nation's entrepreneurs in the small business and self-employed communities strongly believe that the status quo is unsustainable, the measure of success is not simply to produce reform legislation. As some in the media have recently emphasized, the choice is not between the status quo and the bills we have seen emerge from this process. The choice is between flawed legislation and workable alternatives. In short, the legislation must improve the status quo. H.R. 3590 fails to provide those much-needed improvements, and instead makes things worse than they are today. We greatly hope that the Senate will refocus its energy and work with small business to develop the common-sense solutions that make our core needs a top priority.

Sincerely,

Aeronautical Repair Station Association; American Bakers Association; American Farm Bureau Federation®; American Hotel & Lodging Association; American International Automobile Dealers Association; American Rental Association; AMT—The Association For Manufacturing Technology; Associated Builders and Contractors, Inc.; Associated Equipment Distributors; Associated General Contractors of America.

Association For Manufacturing Technology; Association of Ship Brokers & Agents; Automotive Aftermarket Industry Association; Automotive Recyclers Association; Commercial Photographers International; Electronic Security Association; Independent Electrical Contractors; Independent Office Products & Furniture Dealers Alliance; International Foodservice Distributors Association; International Franchise Association.

International Housewares Association; International Sleep Products Association; National Association of Convenience Stores (NACS); National Association of Home Builders; National Association of Manufacturers; National Association of Mortgage Brokers; National Association of Wholesaler-Distributors; National Automobile Dealers Association; National Club Association; National Federation of Independent Business.

National Lumber Building Material Dealers Association (NLBMDA); National Retail Federation; National Retail Lumber Association; National Roofing Contractors Association; National Tooling and Machining Association; National Utility Contractors Association; Northeastern Retail Lumber Association; Precision Machined Products Association; Precision Metalforming Association; Printing Industries of America.

Professional Photographers of America; Self-Insurance Institute of America (SIIA); Service Station Dealers of America and Allied Trades; Small Business & Entrepreneurship Council; Society of American Florists; Society of Sport and Event Photographers; Stock Artist Alliance; The PGA of America; Tire Industry Association; U.S. Chamber of Commerce.

Mrs. HUTCHISON. Mr. President, I am from a State that has big cities, but the vast majority of my State is rural, as is Wyoming and as is South Dakota. I see my employers, my small business owners, which are the largest bulk of the employers in my State, every day. I talk to them or I see them. Unfortunately, we are in Washington every day right now, 7 days a week, but when I am home I see them and when I am here and talking to them on the phone, or they are visiting me, I talk to them and they are aghast. They are aghast that Congress would actually be putting more strain on small business at a time when we know the jobless rate is the highest since World War II and people are trying to do their part to increase our economy and they can't do it with more taxes, more mandates, more burdens. So it is time we look at the tax burden and do something about it.

The Senator from South Dakota and I are trying to do something about it. We are saying, at the very least we should not allow this bill to go forward when the taxes start next month—January 2010—because none of the programming gets up and running until 2014. So we are going to have the mandates and the business taxes and we are going to have the program that is supposed to alleviate the health care crisis in our country in 2014. Shouldn't we start all of the taxes in 2014 rather than asking people to pay for 4 years the taxes that will increase insurance premiums, increase prescription drug costs, and increase medical equipment costs—$100 billion in new taxes on those items—shouldn't we at least put it off until the supposed program comes into place. Because in 4 years, with any luck in America, we won't have these programs start.

There is hope for America that we can stop this program by 2014 as people learn what is in it and protest enough that the Members of Congress who are elected in 2010, elected in 2012, will say: No, we now know that this would be a disaster for our country. There is hope.

I would ask the Senator from Wyoming, when people start learning about the Medicare cuts about which you have spoken so eloquently, and the taxes on the small businesses in your State and all of our States, do you think that perhaps not putting these taxes in place is a good policy, because maybe we can still stop this when people find out what is in it, when it is supposed to take effect 4 years from now?

Mr. BARRASSO. Mr. President, I would respond to my colleague from Texas that I think she is absolutely right. The more people learn about this bill and the details of the bill, the more the American people oppose this bill.

My colleague from Texas made a wonderful point yesterday and again today when she said if they start this

tax collecting right now, do we even know the money is going to be there 4 years from now to start supplying the services. There was a story in today's USA TODAY talking about unemployment in this country, and the story says:

Public Gain, Private Pain. For Federal workers there is a hiring boom. The Federal Government is adding jobs this year at a rate of nearly 10,000 per month.

We have read about all of the different bureaucracies that will be brought into play if this passes: over 70 new bureaucracies, 150,000 more Federal employees, more Washington bureaucrats to make rules and regulations that affect the people of America. It talks about the 10-percent unemployment in the country. It says, it is the new Federal jobs—not the small business jobs, the Federal jobs—that have helped bring down the unemployment rate from 10.2 to 10 percent. It is the Federal jobs.

I am looking at all of this money that Washington is going to collect. I used to think it was a big gimmick so they could say, Well, we have kept the number under $900 billion. I still believe it is a big gimmick, but I am concerned they are going to spend the money as well so the money won't be there, which is the point of the Senator from Texas, who has been very fiscally conservative, out there always making sure we are not spending the taxpayer money in any way that is not a wise use of the money.

Is that one of the concerns the Senator has? I know the Senator from South Dakota has similar concerns: Will the money be there if they are going to hire more Washington bureaucrats, which is what USA TODAY says?

Mr. THUNE. That is exactly what our concern is. I would also add this recent study that came out yesterday by the CMS chief actuary sheds a lot of additional light on what is a very bad proposal, a big government proposal that does create 70 new programs here in Washington, DC, but does nothing to affect in a positive way the health care costs that most Americans are dealing with right now. The actuary goes on to say that access to care problems is plausible and even probable under the Reid bill.

So the issue we have talked about in States such as Wyoming and South Dakota, where people travel long distances to get access to health care, would be aggravated by this legislation because there would be a need for more and more providers—hospitals, physicians—who currently don't take Medicaid patients. You expand Medicare, which is the latest proposal the Democrats have put forward, and as a consequence of that you get fewer and fewer hospitals, fewer and fewer physicians who are accepting Medicare patients, because Medicare and Medicaid are both underreimbursed, therefore creating a cost shift where the cost is shifted over to private payers whose premiums continue to go up and up.

So that is why we see all of these studies coming out saying premiums are going to go up, taxes are going to go up, and Medicare benefits are going to be cut, particularly for seniors who have Medicare Advantage. At the end of the day, this ends up being a $2.5 billion expansion of the government here in Washington, DC.

But to the point the Senator from Texas made—and I think—I know we are running out of time. We want to vote. We want to vote on this motion. We don't think you ought to start taxing people in 21 days and not start delivering benefits for almost 1,500 days.

The ACTING PRESIDENT pro tempore. The time of the Senator has expired.

Mr. THUNE. That is what our motion would do: Synchronize the tax increases with the benefits.

I yield the floor.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that until the Democrats take over, we may continue to talk.

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

Mrs. HUTCHISON. Mr. President, to continue with the Senator from South Dakota, I am glad he made the point because we are very much hoping our amendment will be in the order when we start voting on the health care amendments.

The amendment is so clear; it is very simple. I have it here. For Washington, it is half a page. That is something everyone will be able to appreciate—the motion to commit with instructions:

Senator Hutchison and Senator Thune move to commit the bill to the Committee on Finance with instructions to report back to the Senate with changes to align the effective dates of all taxes, fees, and tax increases levied by such bill so that no such tax, fee, or increase takes effect until such time as the major insurance coverage provisions of the bill, including the insurance exchanges, have begun.

The committee is further instructed to maintain the deficit neutrality of the bill over the 10-year budget window.

That is what was promised. This was going to be deficit neutral. It is not deficit neutral. The cost of this bill is $2.5 trillion over the 10-year period when it starts, in 2014 until 2023. It is $2.5 trillion. The ''offset''—I put that in quotes because the offsets are $500 billion in tax cuts to Medicare, which will lower the ability of hospitals to stay in business and treat Medicare patients and doctors to be able to treat Medicare patients.

So the quality of Medicare is going to go down. Medicare Advantage will be severely restricted. So you have $500 billion in cuts to Medicare, and then you have $500 billion in tax increases and mandates. That is a total of $1 trillion in offsets in a bill that costs $2.5 trillion.

What the Senator from South Dakota and I are trying to do is let's keep our word. Let's keep our word and do two things that the American people should expect: No. 1, that we would not start the taxes until the program takes effect; No. 2, that it would be deficit neutral.

By my math, I ask the Senator from South Dakota, it looks to me like we are $1.5 trillion into the deficit, and we are already at a debt ceiling that is higher than we have had as a percentage of our GDP since World War II. So it is a $12 trillion debt ceiling we are hitting right now, and we are talking about a $1.5 trillion deficit in the bill we are being asked to vote for.

I ask the Senator from South Dakota, who is my cosponsor on this very important amendment, don't we owe the American people the transparency, as well as the policy, that we would eliminate the deficit and we would stop these disastrous taxes from taking effect, so maybe we would have a chance to change this product going forward in the next 4 years so the American people will not be saddled with these expenses, taxes, and mandates?

Mr. THUNE. We do want to get a vote—a vote on our amendment and on other amendments. Right now, that is being prevented or blocked. We haven't had a vote since Tuesday. We have amendments that are ready to go.

The other side said they are open to amendments and they want to get the bill moving forward, but we are being prevented from getting votes on amendments. In the meantime, this backroom deal that is being cut, which we haven't seen—supposedly it has been sent to the CBO to find out what it will cost. We are waiting for that deal to emerge. In the meantime, we are looking at a piece of legislation that costs $2.5 trillion when fully implemented.

As the Senator said, it relies on Medicare cuts and tax increases to finance it. Just yesterday, the chief actuary at the Center for Medicare and Medicaid Services basically said the savings that are relied upon, in terms of Medicare cuts, are unlikely to be sustainable on a permanent basis. They raise the question about whether those cuts are actually going to occur and, if they do, whether they will be sustained. If they are not, then you have the question of whether a lot of these providers out there—if the cuts do occur, and they continue to lose more and more every time they see a Medicare patient, then they are going to quit participating in the Medicare Program. You will have fewer providers offering services, making it more difficult for people—especially in places such as Wyoming and South Dakota—to get access to health care.

You are assuming all these cuts in Medicare are going to occur, and you are assuming all these tax increases. Even with all that, you have a $2.5 trillion expansion of the Federal Government, which inevitably is going to rely more and more on borrowing. You are going to see more and more of this going on the debt, and we will pass it on to future generations.

As CMS pointed out, it is unlikely these Medicare payment cuts are going to be sustainable without driving hospitals and doctors and other health care providers out of business. When they start reacting to this and those Medicare cuts are no longer sustainable, then you have built in all this new spending, and there is no way to pay for it without raising taxes dramatically, which would be, I guess, something the other side—since they have already demonstrated a significant willingness to raise taxes in this bill or borrowing, neither of which is good for the future of the country or our economy.

Right now, our economy is trying to come out of a recession. Small businesses, which create the jobs in our economy, are faced with higher taxes under this bill. They have come forward and said—every conceivable business is saying this will drive up the cost of doing business, and it will raise the cost of health care in this country.

So you have all these small businesses saying we are not going to be able to create jobs. You have that specter out there. You also have the idea of the Medicare cuts, which are, according to the CMS actuary, unlikely to be sustainable, leading to borrowing and debt, which means we are already running a $1 trillion deficit every year and piling more on the Federal debt and there will be a movement here to raise the debt limit by almost $2 trillion. So we will pass this on to future generations, future young Americans, who are going to bear the cost of this massive expansion of the Federal Government.

There isn't anything in this that is good for the American public, which is why they are reacting the way they are, and why you are seeing these 61 percent of Americans coming out in the polls against it.

I say to my friend from Wyoming, his thoughts with regard to this issue, these Medicare cuts being sustainable, how it is going to impact the delivery of health care around this country, and what it will do to future generations in terms of the additional debt and borrowing.

Mr. BARRASSO. As my friend knows, small communities——

Mrs. HUTCHISON. I am sorry to interrupt my friend. I ask unanimous consent that he have 1 minute to finish, after which the floor would go to the majority.

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

Mr. BARRASSO. To follow up, the small communities of this Nation have great concerns about these cuts in Medicare because the small community hospitals that stay open know they have to live within their means. When Medicare cuts total over almost $½ trillion, it is the small communities that have just one hospital in a frontier medicine mode taking care of people who may live 50, 100, or 150 miles away, those hospitals' very survivability is at stake.

That is why we cannot pass this bill, which will hurt seniors, raise taxes on the American people, cost jobs, and cause people who have insurance to have their premiums raised. For all these reasons, this bill is the wrong prescription for America.

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

Mr. DORGAN. Mr. President, first of all, I ask unanimous consent that the amount of time by which the other side went over the allotted time be added to our block of time.

The ACTING PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

PRESCRIPTION DRUG PRICING

Mr. DORGAN. Mr. President, I have come to the floor to speak about something a colleague of mine spoke about last night, which I think he believes separates us when, in fact, it doesn't.

Before I do that, I wish to talk for a moment about the amendment of mine now pending on the floor of the Senate, dealing with the issue of prescription drug pricing.

I offered this amendment, along with my colleague, Senator SNOWE, with the support of a broad bipartisan group of Members of the Senate—Republicans and Democrats—at a time when there has been so few bipartisan amendments. The amendment I have offered is, in fact, bipartisan and had bipartisan speeches in favor of it in the last several days. That is unusual, but I think it is also refreshing.

The amendment is very simple. It has been around for a long time. It has been hard to get passed because the pharmaceutical industry is a very strong, assertive industry. It is a good industry, but I have strong disagreements with their pricing policies. This amendment simply says the American people ought to have the freedom to access FDA-approved drugs wherever they are sold—as long as they are FDA approved—and offered at a fraction of the price they are sold at in the United States.

I ask unanimous consent to show on the floor, once again, two bottles of pills.

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

Mr. DORGAN. This bottle contained Lipitor, perhaps the most popular cholesterol-lowering drug in the world. This was made by an American company in an Irish plant—made in Ireland and shipped around the world. This bottle, as you can see, is identical to this one. One has a red label and one has a blue label.

The only difference in a circumstance, where you have the same pill, put in the same bottle, made by the same company, is the price. Americans pay $4.78 per tablet and, in this case, folks in another country pay $2.05. Why the difference? Again, it is not just one country. This bottle is shipped to virtually every other country, including Great Britain, France, Germany, Spain, Canada, and it is sold at a much lower price.

The question is, Should the American people be required to pay the highest prices in the world for prescription drugs and not have the freedom to access those drugs in the global marketplace?

Some say: Well, if you did that—if you allow the American people to access that drug from Canada or Germany at a fraction of the price, we would get counterfeit drugs.

It is interesting that in our amendment we actually have more safety provisions than exist in our domestic drug supply. There does not now exist a tracing capability, pedigree, or batch lots. That would be a part of our amendment. That doesn't exist for America's drug supply today. We will actually improve the safety of the drug supply with this amendment.

I didn't offer this amendment to cause trouble for people. I know this is causing great angst in the Senate. We have been tied up several days now on this issue. I know the pharmaceutical industry has a great deal of clout. This issue revolves around $100 billion, $19 billion of which will be saved by the Federal Government in the next 10 years and nearly $80 billion saved by the American consumers because they can access FDA prescription drugs at a fraction of the price.

So I understand why some are fighting hard to prevent this. But this is important public policy. The price of prescription drugs has gone up 9 percent this year alone. Every single year, the price of prescription drugs goes up. Every year since 2002, drug price increases have risen above the rate of inflation. We can't, in my judgment, pass health care reform through the Congress and say: Yes, we did that, but we did nothing about the relentless increases in the price of prescription drugs. We will solve that not by imposing price controls but by giving the American people freedom. They are told it is a global economy. Well, it is a global economy for everything except the American people trying to access prescription drugs at a fraction of the price in most other countries.

Again, I didn't offer this amendment to try to cause trouble; I offered this amendment to try to solve a problem. This Congress should not, in my judgment, move ahead with health care reform and decide it ought to leave the question of the American people paying the highest prices for prescription drugs—leave that alone and let that continue to be the case for the next 10 years or the next 20 years. I will speak more about it later.

TRADE WITH CUBA

Mr. DORGAN. Mr. President, I came to the floor to speak about a speech a colleague, for whom I have great affection, gave yesterday on the floor of the

Senate. He was concerned about a provision in the appropriations bill that is now being considered, a provision dealing with the sale of agricultural commodities to Cuba.

My colleague said the provision would undo current law, where the Castro regime in Cuba would have to pay in advance for goods being sold to them because of their terrible credit history.

That is not an accurate statement. I expect there is just a misunderstanding. I would be very happy if my colleague would wish to have a colloquy on the floor to set out the law and the provision in the bill so all of us understand the same thing.

No. 1, I helped write the law that finally opened just a small crevasse—the ability of our farmers in America to sell their agricultural commodities into the Cuban marketplace. Why did I do that? Because we have an embargo on Cuba that, in my opinion, has failed for 40 or 50 years. At the time that embargo included restricting the sale of food to the Cuban people.

I do not think we ought to ever embargo food shipments anywhere in the world. I think it is immoral. I do not think we ever ought to use food as a weapon. Yet that is exactly what has been done.

Our farmers could not sell agricultural commodities into Cuba. Canadian farmers could. French farmers could. German farmers could. American farmers could not.

I changed the law, along with a Republican colleague, with a Dorgan-Ashcroft amendment. We changed the law. We opened it just a crack so American farmers could sell their commodities into the Cuban marketplace. But it had to be for cash. The Cubans had to pay cash in advance. I support that. I helped write the law.

In fact, what I would like to do is put up a copy of the current law. The current law indicates ''cash in advance.'' We have sold about $3 billion of agricultural commodities into the Cuban marketplace since the law was passed, and they have paid cash in advance.

What happened was, President Bush decided just prior to an election that he wanted to send a signal that he was really tightening things with Cuba. He decided to change the definition—not by law but by administrative fiat—and he said ''cash in advance'' will mean the Cubans have to pay for the commodity even before it is shipped from a port in the United States. For four years up to then, the government allowed U.S. farmers to ship the goods from the port and then have the Cubans pay cash when the commodity arrives in Cuba. The President made that change as an attempt to shut down the sale of agricultural commodities to Cuba.

Here is what the Calgary Herald, a Canadian newspaper, said: ''Cuba to Buy $70 Million of Canadian Wheat.'' Then in the body of the article it says:

> Cuban food purchases from Canada will increase 40 percent this year due to difficulties buying from the United States which is requiring payment before shipment of the food sales.

As I said, President Bush tightened the rules to say that ''cash in advance,'' in a law I wrote, shall be interpreted as meaning you must pay even before the shipment. I have never even considered the phrase could be interpreted like that, but that is the way the law is now being administered.

In the pending appropriations bill, there is an amendment I included. It is not, in my judgment, something we ought to debate. It is just there. We ought to understand it. It very simply says this.

> During fiscal year 2010, for purposes of . . . the Trade Sanctions Reform and Export Enhancement Act of 2000 . . . the term ''payment of cash in advance'' shall be interpreted as payment before the transfer of title to, and the control of, the exported items to the Cuban purchaser.

It takes the definition of ''payment of cash in advance'' back it to how it was originally interpreted after I got my bill passed and we started selling into the Cuban marketplace. It restores it to what it was.

My colleague yesterday said this would undo the current law where the Castro regime would have to pay in advance. Obviously, that is not the case. It is just not the case. ''Payment of cash in advance shall be interpreted'' to mean ''payment before the transfer of title to, and control of, the exported items . . . '' There is nothing here suggesting credit be offered to the Cuban regime. This only resolves an issue that was created when President Bush wanted to shut off agricultural commodity shipments to the country of Cuba. As I indicated, the result of the Bush administration's interpretation is what the Calgary Herald wrote about: American farmers, watch the Canadians grab your market.

Why on Earth should we withhold food shipments anywhere? It makes no sense to me. Why should we say to our farmers who produce foods—and we need to export that food—that the Canadians can have an advantage, the Europeans can have an advantage, they can service that market but we cannot, even though we require cash in advance. Lets make it even harder by requiring payment before shipping even. That makes no sense to me. That is why I wanted to correct it. I wanted to correct it to get it back to what the law reads.

My colleague who spoke on this issue yesterday is a good Senator and somebody I like a lot, but he indicates that this amendment of mine undoes current law where the Castro regime would have to pay in advance. That is just not the case. That is not the case.

Maybe the best way for us to resolve this is, let's do a colloquy on the floor to put in the RECORD the exact language, because the shipment of agricultural commodities to Cuba in the future will continue to require cash payments in advance. That is just a fact.

Let me say also, my colleagues—I use the term plural—who feel very strongly about this issue, the Cuba issue, we have common cause. I have no truck for the Cuban Government. I want the Cuban people to be free. I have no sympathy for the Cuban Government. But it is interesting to me that our engagement with Communist China and Communist Vietnam, for example, is to say that constructive engagement through trade and travel is the best way to address those issues. We believe that. Except we say in Cuba that we do not believe it. We restrict the right of the American people to travel to Cuba, which is slapping around the rights of the American people in order to poke our finger in the eye of Fidel Castro, I guess. And we do other things that make no sense.

My colleagues who have raised these issues actually won on one issue that kind of bothers me. I also put an amendment in this legislation that I understand now has been emasculated. Let me describe what that was.

Most people do not know this, but we have airplanes flying over Cuba, at least in international waters, broadcasting television signals to Cuba. I was able to get that shut down in an amendment in the appropriations process because we are broadcasting television signals to Cuba to tell the Cuban people how great freedom is—they can hear that on a Miami station 90 miles away—but we are broadcasting television signals being broadcast by an airplane and the signals are signals the Cuban people cannot see. Isn't that interesting? It is called TV Marti. Here is a picture of what TV Marti broadcasts. That is the television screen for TV Marti. The Cubans block it easily, and the Cuban people do not see it and cannot see it.

We started out broadcasting that with aerostat balloons. They called it Fat Albert. This is the second one. The first one got loose. Fat Albert got loose. It was tethered on a big, long tether, hanging way up in the air, to broadcast television signals to the Cuban people that the Cubans were blocking. So we are spending a lot of money broadcasting television signals that nobody can see. In the first case, we had aerostat balloons, huge balloons, tethered way up in the air, spending millions of dollars a year. One got loose and flew over the Everglades, and they had a devil of a time trying to capture Fat Albert. So they got a second Fat Albert and kept broadcasting signals no one could see. But that wasn't good enough. In fact, they decided: You know what, we are going to get ourselves a big fat airplane and we will fly that airplane around and broadcast signals to Cuba from an airplane. And those signals, too, by the way, are routinely blocked and no one can see them. In my judgment we should not waste that kind of money.

John Nichols, professor of communications and international affairs at Penn State University had this to say.

He is one of the experts on communications policy.

TV Marti's quest to overcome the laws of physics has been a flop. Aero Marti, the airborne platform for TV Marti, has no audience currently in Cuba, and it is a complete and total waste of $6 million a year in taxpayer dollars.

The $6 million is just for the airplane. They spend much more than that on TV Marti.

It is a total and complete waste of $6 million a year in taxpayer dollars. The audience of TV Marti, particularly the Aero Marti platform, is probably zero.

We have been doing this for 10 years and more. Since I raised this issue, we have spent $¼ billion broadcasting television signals into a country that cannot see them.

Let me continue:

TV Marti's response to this succession of failures over a two-decade period has been to resort to ever more expensive technological gimmicks, all richly funded by Congress, and none of those gimmicks, such as the airplane, have worked or probably can work without the compliance of the Cuban Government. It is just the law of physics.

In short, TV Marti is a highly wasteful and ineffective operation.

I put in an amendment that cut $15 million out of this program. I know it is radical to say you should not broadcast to people who cannot see them. I suspect this must be considered some sort of jobs program. That would be the only excuse for continuing funding.

I had an amendment that shut down TV Marti. If ever—ever, ever—there were an opportunity to cut government waste, this is it. This is just a program that accomplishes nothing and has no intrinsic value at all. But in the middle of a very significant economic downturn, when deficits have spiked up, up, way up, I apparently cannot even get this done. I got it done in the Senate, but it did not get through the conference. I guess for the next year or so—Fat Albert is retired—the airplane will still fly. And here is a television set in Cuba sees of TV Marti snow, static. We will continue to spend $15 million or so so the Cubans can look at static on their television sets. It is not much of a bargain for the American taxpayer, I would say.

I only point this out because I lost on this issue. Those who feel strongly that we ought to continue to do this won. I hope that one day, perhaps we could agree that when we spend money, let's spend it on things that work, spend it on things that are effective, spend it on things that advance our interest and our values. This certainly does not.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Pennsylvania.

HEALTH CARE REFORM

Mr. CASEY. Mr. President, I rise this morning to speak about health care and our children and the health care reform, the Patient Protection and Affordable Care Act, as relates to our children.

The chart on my left makes a couple of fundamental points.

For children, health care reform must follow one simple principle, and I also say it is only four words: No child worse off. When I say ''no child,'' of course I am speaking of children who do not often have a voice. Obviously, if they are children from a family that is very wealthy, I think they will be just fine no matter what happens here. But children who are poor and children who experience and have to live with special needs are the ones I am talking about when I say ''no child worse off.''

I filed many weeks ago—actually, months ago now—a joint resolution, No. 170. I was joined in that resolution by Senator DODD, Senator ROCKEFELLER, Senator BROWN, Senator WHITEHOUSE, and Senator SANDERS. We filed that resolution just to make this point with a couple more words than ''no child worse off,'' but that was the fundamental point to guide us through this process because sometimes in a debate on something that is this significant, and parts of it are complicated to be enacted into law—it is a challenge to pass health care reform. I think we will. I think we must. But we do need guiding principles, and I believe one of these should be ''no child worse off'' for special needs children.

A lot of the child advocates across America have told us, for many years, something so simple but something very meaningful in terms of providing further guidance for this debate. Children are not small adults. That does not sound so profound, but it really matters when it comes to health care. We can't just say: If you have a health care plan for adults, it will work for kids, do not worry about it. Unfortunately, that is not the case.

If we do not do the right thing, we could lose our way on that basic principle. We have to get it right, and we have to give poor and special needs children a voice in this debate. I do not think there is any question that Senators on this side of the aisle are guided by that basic principle.

I want to next turn to the bill, the Patient Protection and Affordable Care Act, and walk through some of the provisions. There are many good provisions in the bill for children, but I want to walk through a couple.

How does it help children? That is a fundamental question. You cannot escape the basic implications of that. First, the bill eliminates preexisting condition exclusions. That is in the first couple pages of the bill. Obviously, it has an enormously positive impact for adults. We have heard story after story of literally millions of Americans denied coverage year after year because of the problem of preexisting conditions. It has special meaning when it comes to children.

No. 2, the bill ensures that benefits packages include oral and vision care. We know what that means for children, and in particular we are thinking about the horrific, tragic, and preventable death recently of Deamonte Driver of Maryland, a young boy who lost his life because his family did not have the coverage for an infected tooth—an infected tooth, not something that is complicated to deal with. His family couldn't afford the care. A child in America died from an infected tooth that would have cost $80 to treat.

So when we talk about insuring benefit packages that include oral and vision care, that doesn't say it too well until you connect it to the life and the death—the tragic death—of a young child not too far from Washington, DC.

Thirdly, the Patient Protection and Affordable Care Act will mandate prevention and screenings for children. This is so important. We know our poorest children, who have the benefit of being covered by Medicaid, get these kinds of services so we can prevent a child from getting sicker or prevent a disease or a condition or a problem from becoming that much worse for that child.

As I said before, children are not small adults, so we have to make sure we have strategies and procedures in place that deal with the special needs and the special challenges that children face in our health care system.

Finally, the act has increasing access to immunizations. I don't think I have to explain to any American how important immunizations are. The Centers for Disease Control will provide grants to improve immunizations for children, adolescents, and adults.

Let me move to the third chart. The third chart outlines some other provisions for children. Here are three more ways the Patient Protection and Affordable Care Act helps children, among many others. It creates pediatric medical homes. People may say: What is a medical home? What does that mean? Well, I need simplicity just like anyone does. This is my best summary of a medical home.

A medical home obviously isn't a place. It is treating people in the way they ought to be treated in our health care system. The ideal—and I think this bill gets us very close to meeting this goal—is that every American should have a primary care physician and then be surrounded by the expertise of our health care system. Children especially need that kind of help. So we want to make sure every child not only has a primary care physician—in this case a pediatrician—but also has access to all of the expertise that pediatricians and our system can give them access to.

Next, the act strengthens the pediatric workforce. We can't just say we want children to have access to pediatric care. We have to make sure we have the workforce in America to provide that kind of care.

Thirdly, the act expands drug discounts to children's hospitals. Before this act, before the act that we are debating, children's hospitals did not have access to a program that provides discounts on the drugs they need for

sick children. Now children will benefit from the discounted prices that result from the passage of this act. This is vitally important.

Let me go to one more chart.

Parliamentary inquiry, Mr. President: How much time do I have remaining?

The ACTING PRESIDENT pro tempore. Two minutes.

Mr. CASEY. Two minutes. I will just do one chart and then we will move quickly.

This chart makes a very fundamental point. At a time in our history when over the course of a year the national poverty rate went up by 800,000, and the number of people without insurance is going up—and in the midst of a recession, you would understand and expect that—the one thing we don't focus on is that because of the effectiveness of the Children's Health Insurance Program, there is one number on this chart that is going down—and we hope it keeps going down—and that is the number of uninsured children.

It is interesting that on this chart between 2007–2008, as the child poverty rate went up by 800,000 children, the number of children without insurance is down by that same number—800,000. It shows the Children's Health Insurance Program is working, even in the midst of a recession. So I have an amendment that strengthens the Children's Health Insurance Program in the bill.

I know I am out of time, Mr. President, and I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Illinois.

Mr. DURBIN. Mr. President, it is my understanding that we have gone over the original allocation of time, and Senator MCCAIN is coming to the floor. We will, of course, offer to the minority side whatever extra time we will use so that there will be a like amount available to them, and I will make every effort to shorten my remarks.

The ACTING PRESIDENT pro tempore. The majority has not exceeded its time. There is 12 minutes remaining on the clock.

Mr. DURBIN. Sorry, I was misinformed. But whatever we promised the minority side, they will receive like treatment on whatever time we use.

UNANIMOUS CONSENT REQUEST—H.R. 3590

Mr. DURBIN. Mr. President, yesterday, the majority leader propounded a unanimous consent request to have four votes with respect to the health care bill. The Republican leader objected to the consent, since he indicated they had just received a copy of Senator LAUTENBERG's side-by-side amendment to the Dorgan amendment and so they needed time to review the amendment.

Therefore, I now ask unanimous consent that following the period of morning business today, the Senate resume consideration of H.R. 3590 for the purpose of considering the pending Crapo amendment to commit and the Dorgan amendment, No. 2793, as modified; that Senator BAUCUS be recognized to call up a 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 the 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 a 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; and 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, and that the above referenced amendments and motion to commit be subject to an affirmative 60-vote threshold; that if they achieve that threshold, they then be agreed to and the motion to reconsider be laid upon the table; if they do not achieve that threshold, they then be withdrawn.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Mr. President, reserving the right to object, we are going to have three Democratic amendments and one Republican amendment voted on, and the Democrats wrote the bill. The Democrats are doing a side by side to their own amendment.

It looks to me like they ought to get together and get some things figured out. There ought to be a little bit more fairness on the number of amendments. So I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. DURBIN. Mr. President, this is the second time we have offered to call amendments for a vote, and the complaint from the other side is, you are not calling amendments for a vote.

How many times do we have to ask for permission to call amendments for a vote, run into objections from the Republican side, and then hear the speech: Why aren't we voting on amendments?

I am certain that in the vast expansion of time and space, we can work out something fair in terms of the number of amendments on both sides. In fact, maybe the next round will have more Republican amendments than Democratic amendments. I don't know how many Republican amendments or Democratic amendments we have voted on so far. We can get an official tally, but that really seems like a very minor element to stop the debate on health care—because we need to have an equal number of amendments. Can't grownups work things out like this and with an understanding that we will resolve them? If we can't, then for goodness' sake don't subject us to these arguments on the Senate floor that we are not calling amendments for a vote. We have just tried 2 days in a row, and the Republicans once again have stopped us with objections. That is a fact.

I would implore the leadership—not my friend from Wyoming; I know he is doing what he is instructed to do by the leaders—for goodness' sake, let's break this logjam. Let's not, at the end of the day, say, well, we stopped debating this bill when we should have been debating it, when we have offered 2 days in a row in good faith to have actual amendments offered and debated.

I would also say, Mr. President, this is the bill we are considering, H.R. 3590, when we return to it. This is the health care reform bill, and this is a bill which has been the product of a lot of work. A lot of work has gone into it both in the House and in the Senate. In the Senate, two different committees met literally for months writing this bill, and they should take that time because this is the most significant and historic and comprehensive bill I have ever considered in my time in Congress—more than 25 years. This bill affects every person in America—every person in the gallery, everyone watching us on C–SPAN, every person in America. It addresses an issue that every American is concerned about—the future of health care, how we are going to make it affordable.

At a time when fewer businesses offer the protection of health insurance, at a time when individuals find themselves unable to buy health insurance that is good and that they can afford; at a time when health insurance companies are turning down people right and left for virtually any excuse related to preexisting conditions, we cannot continue along this road. Those who are fighting change, those who are resisting reform, are basically standing by a broken system.

There are many elements in American health care that are the best in the world, but the basic health care system in America is fundamentally flawed. This is the only civilized Nation on Earth where you can die for lack of health insurance—literally die.

Mr. President, 45,000 people a year die because they do not have the health insurance they need to bring them to the doctor they need at a critical moment in life. They do not have the health insurance they need to afford the surgical procedure they need to avoid a deadly disease.

If a person has a $5,000 deductible on their health insurance, and a doctor tells them—as a man who wrote me from Illinois said—you should have a colonoscopy, sir; there is an indication you could have a problem that could develop into colon cancer and it could be fatal.

The man says: How much is the colonoscopy?

Well, it is $3,000 out of pocket.

The man says: I can't afford it. I just can't pay for it.

So he doesn't get the colonoscopy and bad things can occur. That happens in America, but it doesn't happen in any other civilized country.

It is true in some systems he may have had to wait an extra week or a month, but he gets the care he needs. He doesn't die for lack of health insurance. That is what is going on in America. Almost 50 million Americans without health insurance today—almost 50 million in this great and prosperous Nation—went to bed last night without the peace of mind of the coverage of health insurance. This bill addresses that.

At the end of the day, 94 percent of the people living in America will be able to sleep at night knowing they have a decent health insurance plan. That is an amazing step forward. That is a step consistent with the establishment of Social Security, which finally took the worry away from seniors and their families about what would happen to grandma and grandpa when they stopped working.

I remember those days. There was a time when grandma and grandpa retired and moved in with their kids. Remember that era? I do. It happened in our family, and they didn't have any choice. They had to because they had modest jobs and not a lot of savings and they put it on their kids to find that spare bedroom or let them sleep in basement that was made over so that they would have a comfortable and safe place to be.

Social Security changed that for most American families. This bill will change health care for most American families. The same thing is true with Medicare. The critics of Medicare—and they have been legion on the floor of the Senate—ignore the obvious: 45 million Americans will have peace of mind to know that they can get affordable health care once they reach the age of 65. They would not lose their life savings. They will get a good doctor, a good hospital, and a good outcome.

Isn't that what America is all about? Isn't that why we are supposed to be here? Why don't we have more support? The Republican side of the aisle only comes to say what is wrong with the idea of health care.

Steven Pearlstein, in this morning's Washington Post—which I hope some of my Republican colleagues will read—talks about a lost opportunity which the Republicans have.

We have invited the Republicans from day one to be part of the conversation about health care reform. Senator ENZI of Wyoming is one who assiduously gave every effort, spent 61 days trying to reach a bipartisan agreement. It failed, but at least he tried. I commend him for trying.

Too many others on the other side didn't try. But Steven Pearlstein writes:

> One can only imagine how Republicans could have reshaped health-reform legislation in the Senate . . . Without question, they could have won more deficit-reducing cost savings in the Medicare program by setting limits on spending growth and reforming the way health care is organized, provided and paid for. And they could have begun to realize their goal of ''consumer-driven health care'' by insisting that the new insurance exchanges offer at least one plan built around individual health savings accounts and catastrophic coverage.

Pearlstein goes on to talk about the possibilities. He says:

> They could have taken a page from John McCain's platform and insisted on replacing the current tax exclusion of health-care benefits with a flat tax credit that would be more progressive and put downward pressure on insurance premiums.

I am not guaranteeing that any of those proposals would have been in, but they all could have been in if we had a dialog. Instead of a dialog, we have a shouting match, one side of the aisle shouting at the other side of the aisle. It is exactly the stereotype of Washington which America has come to hate. America wants us to solve problems, not get into these, you know, fur-flying debates, where we see who can get the rhetorical better of the other. They want us to solve problems but, unfortunately, we are still waiting for the first Republican to cross the aisle on the passage of this bill and work with us. The door is still open. The invitation is still there. The idea of doing nothing is unacceptable and that should be the message.

The fact is, there is no comprehensive Republican health care reform bill—period. Senators come to the floor, such as Senator COBURN, and say: I have some good ideas. I bet he does. I may even subscribe to them. But his ideas have not gone through the rigor this bill has gone through. This bill was sent to the Congressional Budget Office and scored, asking the basic questions: No. 1, will it add to the deficit? They came back and told us: No, the Democratic health care reform bill will, in fact, save money, $130 billion in 10 years; $650 billion in the second 10 years. We asked them: Is it going to insure more Americans? They came back and said: Yes, 94 percent will be insured when this is over. That same rigor has not been applied to the Republican ideas because it is hard, it is tough, and it takes time. I commend them for their thoughtful ideas, but to say they have something they can match against this bill, comprehensive reform—just go to the Republican Senate Web site and look for the Republican comprehensive reform bill. Do you know what you will find? You will find the Democratic bill. That is all they can talk about. They don't have a comprehensive health care reform bill.

But we are not going to quit. America, we cannot go home for Christmas until we get this job done.

After we have been here 12 straight days debating, we kind of get into a trance-like, catatonic state, where we can't remember what our last speech was about and we go to sleep at night thinking about what we might have said on the floor or what we are going to say tomorrow. But the fact is, we have to stay and do our job, not just in passing health care reform but doing something significant to help the unemployed and deal with jobs and the economy before we leave here to try to enjoy Christmas, or what is left of it or the holiday season, with our families.

This is a job that has to be done. I am sorry we have reached a point where the Republicans have not been actively involved in creating this bill. We tried for the longest time. In the HELP Committee, where Senator ENZI serves as the ranking Republican, more than 100 Republican amendments were accepted as part of this debate and still not one single Republican Senator would vote for the bill in that committee.

So far the scorecard on Republican participation in health care reform debate is a lot of speeches, a lot of press releases, a lot of charts on the floor but only two votes—one from a Republican Congressman in Louisiana for the House bill; one from Senator SNOWE of Maine for the Senate Finance version of this bill.

The ACTING PRESIDENT pro tempore. The time of the majority has expired.

Mr. DURBIN. That is it. I urge my colleagues to join us in a cooperative effort to try to come up with something more positive than just our lonely speeches on the floor.

The ACTING PRESIDENT pro tempore. The time of the Senator has expired. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, while my friend from Illinois——

Mr. DURBIN. Mr. President, I ask unanimous consent morning business be closed. I wish to make sure Senator MCCAIN has time.

Mr. MCCAIN. I ask for an additional 10 minutes of morning business so I could maybe engage in a colloquy with my favorite combatant here.

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

Mr. MCCAIN. Maybe we can talk a little bit about his remarks.

I have to say, I appreciate the eloquence and the passion the Senator from Illinois has brought to this debate. He makes some very convincing points. One of the major points—and I would be glad to listen to the Senator. I think it is fair for us to respond to each other's comments very quickly. The Senator from Illinois said we have been engaged in the negotiations and inputs have been made into the formulation of this bill.

I have to tell the Senator from Illinois, I have been engaged in many bipartisan compromises, whether it be issues such as campaign finance reform, whether it be—a whole large number of issues, including defense weapons acquisition reform. I say to the Senator from Illinois, do you know what the process was? People sat down

at the table together when they were writing the legislation. I am a member of the HELP Committee, OK? I say to the Senator from Illinois, do you know what the process was—because I am on the committee. A bill was brought before the committee without a single—Senator ENZI will attest to this—without a single period of negotiations, where we sat down together with the chairman of the committee, where they said: What is your input into this legislation?

We had many hours of amendments in the committee, all of which, if they were of any real substance, were rejected on a party-line vote.

I have to tell the Senator from Illinois he can say all he wants to that there have been efforts to open this to bipartisanship. There have not. My experience in this Senate—I know how you frame a bipartisan bill and that has not been the process that has been pursued by the majority.

I understand what 60 votes mean. But in all due respect, I say to the eloquence of my friend from Illinois, that has not been the process which I have successfully pursued for many years, where people have sat down together at the beginning, where you are there on the takeoff and also then on the landing.

I would be glad to hear the response of the Senator from Illinois.

I ask unanimous consent if the Senator and I could engage in a colloquy.

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

Mr. DURBIN. First, those who are watching, this is perilously close to a debate on the floor of the Senate, which rarely occurs in the world's most deliberative body, where Senators with opposing views actually, in a respectful way, have an exchange. I thank the Senator——

Mr. MCCAIN. Respectful but vigorous.

Mr. DURBIN. I thank the Senator from Arizona. Here is what I understood happened. I know Senator DODD came to the HELP Committee with a base bill to start with, but it is my understanding, in the process, 100 Republican amendments were accepted on that bill. If I am mistaken, I know the Senator will correct me, but——

Mr. MCCAIN. I will be glad to correct the Senator from Illinois. Senator ENZI is here. None of those amendments were of any significant substance that would have a significant impact on the legislation, I have to say to the Senator from Illinois. For example, medical malpractice, we proposed several amendments that would address what we all know, what the Congressional Budget Office says is $54 billion—other estimates as much as $100 billion—in savings. There were no real fundamental amendments.

I have to say that some of those amendments were accepted. But it still doesn't change the fact that at the beginning, as the Senator from Illinois said—the bill came to the committee without a bit, not 1 minute of negotiation before the bill was presented to the committee. The ranking member is on the floor. He will attest to that. Please go ahead.

Mr. DURBIN. I would say to the Senator from Arizona, I went through bankruptcy reform with Senator GRASSLEY and a similar process was followed when the Republicans were in the majority. He produced the base-line bill, and I made some modifications and, ultimately, at one point in time, we agreed on a bill, came up with a common bill. The starting point is just that, a starting point. But I say to the Senator from Arizona, look at what happened to the issue of public option. I believe in public option passionately. I believe it is essential for the future of health care reform, for competition for private health insurance companies to give consumers a choice, to make sure we have one low-cost alternative at least in every market. Yet, at the end of the day, I did not get what I wanted and what is being proposed, now at the Congressional Budget Office, is not my version of public option.

We ended up bending toward some of the more moderate and conservative members of the Democratic caucus and toward the Republican point of view. I don't know of a single Republican who came out for public option. Maybe I am forgetting one. At the end of the day, the point I am making to the Senator is there was an effort at flexibility and an effort at change to try to find some common ground. Unfortunately, the ground we are plowing has only 60 Democratic votes. It could have been much different. It could still be much different.

Mr. MCCAIN. May I ask my friend, wasn't the reason the public option was abandoned was not because of a Republican objection, it was because of the Democratic objection? The Senator from Connecticut stated, unequivocally, the public option would make it a no deal.

I appreciate the fact that Republican objections were observed. But I don't believe the driving force behind the abandonment of this public option, if it actually was that—we have not seen the bill that is going to come before us—was mainly because of the necessity to keep 60 Democratic votes together.

Mr. DURBIN. The Senator from Arizona is correct. But I add, Senator SNOWE has shown, I believe, extraordinary courage in voting for this bill in the Senate Finance Committee and made it clear she could not support the public option. We are hoping, at the end of the day, she will consider voting for health care reform. That was part of the calculation.

Mr. MCCAIN. We are hoping not.

Mr. DURBIN. I understand your point of view, but I would say—you are right. But we were moving toward our 60 votes, but it would be a great outcome if we end up with a bill that brings some Republicans on board, and it was clear we couldn't achieve that if we kept the public option in. There are other elements here. We are going to have a real profound difference when it comes to the issue of medical malpractice and how to approach it. But I think, even on that issue, we could have worked toward some common ground, and I hope someday we still can.

Mr. MCCAIN. Could I ask my friend about the situation as it exists right now? Right now, no Member on this side has any idea as to the specifics of the proposal the majority leader, I understand, has sent to OMB for some kind of scoring. Is that the way we want to do business, that a proposal that will be presented to the Senate sometime next week and voted on immediately—that is what we are told—is that the way to do business in a bipartisan fashion? Should we not at least be informed as to what the proposal is the Senate majority leader is going to propose to the entire Senate within a couple days? Shouldn't we even know what it is?

Mr. DURBIN. I would say to the Senator from Arizona, I am in the dark almost as much as he is, and I am in the leadership. The reason is, because the Congressional Budget Office, which scores the managers' amendment, the so-called compromise, has told us, once you publicly start debating it, we will publicly release it. We want to basically see whether it works, whether it works to continue to reduce the deficit, whether it works to continue to reduce the growth in health care costs.

We had a caucus after this was submitted to the Congressional Budget Office, where Senator REID and other Senators who were involved in it basically stood and said: We are sorry, we can't tell you in detail what was involved. But you will learn, everyone will learn, it will be as public information as this bill currently is on the Internet. But the Congressional Budget Office has tied our hands at this point putting it forward. Basically, what I know is what you know, having read press accounts of what may be included.

Mr. MCCAIN. Could I ask my friend from Illinois—and by the way, I would like to do this again. Perhaps when he can get more substance into many of the issues.

Mr. DURBIN. Same time, same place tomorrow?

Mr. MCCAIN. I admit these are unusual times. But isn't that a very unusual process, that here we are discussing one-sixth of the gross national product; the bill before us has been a product of almost a year of sausage-making. Yet here we are at a position on December 12, with a proposal that none of us, except, I understand, one person, the majority leader, knows what the final parameters are, much less informing the American people. I don't get it.

Mr. DURBIN. I think the Senator is correct, saying most of us know the

fundamentals, but we do not know the important details behind this. What I am saying is, this is not the choice of the majority leader. It is the choice of the Congressional Budget Office. We may find that something that was sent over there doesn't work at all, doesn't fly. They may say this is not going to work, start over. So we have to reserve the right to do that, and I think that is why we are waiting for the Congressional Budget Office scoring, as they call it, to make sure it hits the levels we want, in terms of deficit reduction and reducing the cost of health care.

It is frustrating on your side. It is frustrating here. But I am hoping, in a matter of hours, maybe days, we will receive the CBO report.

I would like to ask the Senator from Arizona, if he wouldn't mind responding to me on this. Does the Senator believe the current health care system in America is sustainable as we know it, in terms of affordability for individuals and businesses? Is the Senator concerned that more and more people do not have the protection of health insurance; fewer businesses offer that protection?

The ACTING PRESIDENT pro tempore. The 10-minute time period has expired.

Mr. McCAIN. I ask unanimous consent for 5 additional minutes.

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

Mr. DURBIN. Is the Senator concerned as well with the fact that we have 50 million Americans without health insurance and the number is growing; that in many of the insurance markets across America there is no competition, one or two take-it-or-leave-it situations? Does that lead him to conclude we cannot stay with the current system but have to make some fundamental changes and reforms?

Mr. McCAIN. I say to my friend, everything he said is absolutely correct. I am deeply concerned about the situation of health care in America. I know the Senator from Illinois is deeply concerned about the fact that it is going to go bankrupt, about the fact that the Medicare trustees say that within 6 or 7 years it is broke. From what we hear, there is now a proposal over there to extend eligibility for Medicare, which obviously puts more people in the system, which obviously, under the present setup, would accelerate a point of bankruptcy, at least from what I know of this.

But the fundamental difference we have, in my opinion, is not what we want—we both share the deep ambition that every American has affordable and available health care—it is that we believe a government option, a government takeover, a massive reorganization of health care in America will destroy the quality of health care in America and not address the fundamental problem. We believe the quality is fine.

We think the problem is bringing costs under control. When you refuse to address an obvious aspect of cost savings such as malpractice reform, such as going across State lines to obtain health insurance, such as allowing small businesses to join together and negotiate with health care companies, such as other proposals we have, then that is where we have a difference. We share a common ambition, but we differ on the way we get there. I do not see in this bill, nor do most experts, a significant reduction in health care costs except slashing Medicare by some $½ trillion, which everybody knows doesn't work, and destroying the Medicare Advantage Program of which in my home State 330,000 seniors are a part.

Mr. DURBIN. I say to the Senator two or three things. First, the CBO tells us this bill will make Medicare live 5 years more. This bill will breathe into Medicare extended life of 5 additional years. Second, I have heard a lot of negative comments about government-sponsored health care. I ask the Senator from Arizona, is he in favor of eliminating the Medicare Program, the veterans care program, the Medicaid Program, the CHIP program to provide health insurance for children, all basically government-administered programs? Does he believe there is something fundamentally wrong with those programs that they should be jettisoned and turned over to the private sector?

The second question, does the Senator from Arizona want to justify why Medicare Advantage, offered by private health insurance companies, costs 14 percent more than the government plan being offered, and we are literally subsidizing private health insurance companies to the tune of billions of dollars each year so they can make more profits at the expense of Medicare?

Mr. McCAIN. First, obviously I want to preserve those programs. But every one of those the Senator pointed out is going broke. They are wonderful programs. They are great things to have. But they are going broke. He knows it and I know it, and the Medicare trustees know it. To say that we don't want these programs because we want to fix them is obviously a mischaracterization of my position, our position. We want to preserve them, but we all know they are going broke. It means cost savings. It means malpractice reform. It means all the things I talked about. The Senator mentioned Medicare Advantage. That is called Medicare Part C. That is part of the Medicare system. There are arguments made that there are enormous savings over time because seniors who have this program, who have chosen it, who haven't violated any law, are more well and more fit and have better health over time, thereby, in the long run, causing significant savings in the health care system which is what this is supposed to be all about. I ask in response: How in the world do you take a Medicare system which, according to the trustees, is going broke and then expand it to people between age 55 and 64? The math doesn't work. It doesn't work under the present system which is going broke. To add on to it, any medical expert will tell you, results in adverse selection and therefore increases in health care costs.

Mr. DURBIN. If I may respond, why is Medicare facing insolvency? Why is it going broke? Why are the other systems facing it? Because the increase in cost in health care each year outstrips inflation. There is no way to keep up with it unless we start bending the cost curve. We face that reality unless we deal with the fundamentals of how to have more efficient, quality health care. Going broke is a phenomena not reflective in bad administration of the program but in the reality of health care economics.

What I am about to say about the expanded Medicare is based solely on press accounts, not that I know what was submitted to CBO in detail. I do not. But the 55 to 64 eligibility for Medicare will be in a separate pool sustained by premiums paid by those going in. If they are a high-risk pool by nature, they will see higher premiums. What happens in that pool will not have an impact on Medicare, as I understand it. It will be a separate pool of those receiving Medicare benefits that they will pay for in actual premiums. It won't be at the expense or to the benefit of the Medicare Program itself. What I have said is based on press accounts and not my personal knowledge of what was submitted to CBO.

Mr. McCAIN. The Senator has seen the CMS estimates this morning that this will mean dramatic increases in health care costs. You may be able to expand the access to it, but given the dramatic increase, one, it still affects the Medicare system and, two, there will obviously be increased costs, if you see the adverse selection such as we are talking about.

I see the staff is getting restless. I ask my friend, maybe we could do this again during the weekend and during the week. I appreciate it. I think people are helped by this kind of debate. I respect not only the passion but the knowledge the Senator from Illinois has about this issue.

Mr. DURBIN. I thank the Senator.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

TRANSPORTATION, HOUSING AND URBAN DEVELOPMENT, AND RELATED AGENCIES APPROPRIATIONS ACT, 2010—CONFERENCE REPORT—Resumed

The PRESIDING OFFICER (Mr. BEGICH). The clerk will report.

The bill clerk read as follows:

Conference report to accompany 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.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Mr. President, one of the troubling aspects of this conference report is that the appropriators air dropped three very significant spending bills into the text during conference. In other words, three bills without any debate, discussion or amendment were air dropped into this pending legislation. The three bills are the Labor-HHS-Education, financial services and general government, and the State-Foreign Operations appropriations bills. Combined, these three bills spend over $237 billion and contain 2,019 earmarks. It is remarkable and unacceptable that the Senate is willing to approve expenditure of such huge sums without the opportunity to debate and amend their content.

I see the Senator from Hawaii, who will say: This is the way we have had to do business before. We have to do this because of the pressure of time, the fiscal year ended, et cetera, et cetera. Again, we get back to this old line that we heard for an entire year and even early this year about change, about how we were going to change things in Washington. We are going to change the way we do business.

President Obama said about the last omnibus bill passed last March, 3 months into the Obama administration:

The future demands that we operate in a different way than we have in the past. So let there be no doubt: this piece of legislation must mark an end to the old way of doing business and the beginning of a new era of responsibility and accountability that the American people have every right to expect and demand.

What are we doing today? The exact same thing that we were doing before.

Here is a quote from the White House Chief of Staff Rahm Emanuel about the last omnibus bill. This is the one we weren't going to do anymore.

Second, this is last year's business.

He was talking about the one we passed in March.

And third, most importantly, we are going to have to make some other changes going forward to reduce and bring more—reduce the ultimate number and bring the transparency. And that's the policy that he enunciated in his campaign.

Bob Schieffer:

But it sounds to me like what you're—what he's about to do, here, is say, well I don't like this but I'm going to go ahead and sign it—

Talking about the last omnibus bill—

but I'm going to warn you, don't ever do it again. Is that what's about to happen here?

Emanuel:

In not so many words, yes.

And then, of course, the Senate majority leader said about the last omnibus:

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 with working with President Bush.

I wonder if we are going to blame President Bush for this one. If it rained, if it didn't rain? We blamed him for almost everything. Whatever it is, let's blame President Bush. The point is, what this bill is, and another one that will be coming up in a couple days, is exactly the same business as usual, a porkbarrel-laden bill with increases in spending when the American people are hurting in the worst possible way. The American people are hurting and the Labor, Health and Human Services and Education appropriations bill has $11.3 billion or a 7-percent increase in spending over last year's spending level. Where are we? This is America. Americans are hurting. There is 10 percent unemployment. People can't stay in their homes. They can't keep their jobs. We are passing a piece of legislation with 1,749 earmarks just in the Labor, Health and Human Services piece of over $806 billion.

Do you want to hear a few of them? They are fascinating. Here is my favorite of all—there are a lot of good ones—$2.7 million to support surgical operations in outer space at the University of Nebraska. I assure my colleagues, I am not making that up. That is an appropriation in this bill. Let me repeat: $2.7 million to support surgical operations in outer space. There are a lot of compelling issues before the American people. Surgical operations in outer space at the University of Nebraska? I guess the University of Nebraska has some kind of expertise that they need $2.7 million so we could support surgical operations in outer space. I wonder when the next surgical operation is scheduled in outer space? Maybe we ought to go into that.

I will be spending more time on the floor on this. But $30,000 for a Woodstock film festival youth initiative? Woodstock was a pretty neat experience, but do we need to spend $30,000 to revisit that one? There is $200,000 to renovate and construct the Laredo Little Theater in Texas. The next time you are in Laredo, be sure to stop by the theater and see $200,000 of your money which is going to renovate and construct this little theater. There is $500,000 for the Botanical Research Institute of Texas in Fort Worth; $200,000 for a visitors center in Bastrop, TX, a visitor center there in Bastrop with a population of 5,340 people. We are going to spend $200,000 of my taxpayers' dollars to build them a visitor center. There is $200,000 for design and construction of the Garapan public market in the Northern Mariana islands; $500,000 for development of a community center in Custer County, ID, population 4,342. If my math is right, that is about $100 per person. Right here in our Nation's Capital, $200,000 to the Washington National Opera for set design, installation and performing arts at libraries and schools. They have an operating budget of $32 million. Their Web site says the secret of its success is due to its position without the crucial government support typical in most world capitals. Then, of course, we always get back to Hawaii: $13 million on fisheries in Hawaii, nine projects throughout the islands ranging from funding the bigeye tuna quotas, marine education and training, and coral research.

The list goes on and on. The next time you are in New York, go to Lincoln Center. We are spending $800,000 of your money for jazz at the Lincoln Center. Jazz lovers, rejoice. For those who are not jazz lovers, we have $300,000 for music programs at Carnegie Hall; $3.4 million for a rural bus program in Hawaii. Apparently, the $1.9 million in the 2009 omnibus was not enough. In other words, we gave $1.9 million for this rural bus program in Hawaii so we have to now give them $3.4 million more.

Custer County, ID, with a population of 4,342, as of the year 2000—I am sure they have grown since—$500,000 for development of a community center in Custer County, ID.

The list goes on.

Then, of course, it is loaded with controversial policy riders that should have been debated in the Senate.

In the Department of Labor bill, the conference rescinds $50 million from unobligated immigration enforcement funds under section 286(v) of the Immigration and Nationality Act. This will result in a decrease in the enforcement of immigration law. I guarantee you, if that provision had been debated here on the floor of the Senate, that $50 million would never have been removed.

The conference agreement includes new language providing authority to the International Labor Affairs Bureau, the agency charged with carrying out the Department of Labor's international responsibilities. This may be a worthy program, but it should be addressed in legislation.

There are so many other policy provisions in this bill which have not been authorized, which is supposed to be done by authorizers.

The conference agreement provides $35 million for the Delta Health Initiative. The Delta Health Initiative provides a service to individuals in only one area of the country, the delta region of Mississippi. I have visited the delta region in Mississippi, and there are severe health needs. But couldn't we authorize this program? Couldn't we authorize it? Couldn't we have the proper debate and discussion?

The list goes on and on.

Of course, there is $25 million ''for patient safety and medical liability reform demonstrations'' that was not included in the House or Senate. Medical liability reform demonstrations—there is a demonstration project already in being. It is called the State of Texas, where they have reduced medical malpractice costs dramatically, and the physicians and caregivers are flowing back into the State of Texas.

Mr. President, I will be talking more later this afternoon about all the pork and earmarking that is in this bill.

I have to tell you that the anger and the frustration out there is at an incredibly high level. Those of us who—I am sure most of us do—spend a lot of time at townhall meetings and hearing from our constituents know there is a level of anger out there, the likes of which I have not seen before. Here they are, hurting so badly because they cannot keep their homes and their jobs. My home State of Arizona is No. 2 in the country of homes where the mortgage payment is higher than the home value—48 percent of the homes in my State. So here we are with 10-percent unemployment, with deficits—this year of $1.4 trillion—and there are dramatic increases, a 7-percent increase in spending in one, a 14-percent increase in spending in the other, and they do not get it. They do not get it. They do not get it. Americans are having to tighten their belts.

My home State of Arizona is in a fiscal crisis. They are having to cut services to our citizens because we cannot print money in Arizona. They only print money here. And here we are with Omnibus appropriations bills with as high as a 14-percent increase in spending, loaded down with billions of dollars worth of porkbarrel projects.

I predict to my colleagues that the anger out there will be manifest in a number of peaceful ways, including in the ballot booth. They are sick and tired of this. I saw a poll yesterday where the approval rating of Members of Congress has fallen below that of the approval rating for used car salespersons. I think it was at 4 percent, as I recall the poll. I have not met any of the 4 percent. I have not met anybody who approves of what we are doing.

This exercise we are in right here, on December 11, 2009, with a pork-laden Omnibus appropriations bill which frivolously and outrageously spends their dollars when they are struggling to keep their heads above water is something that is going to be rejected sooner or later by the American people. I have warned my colleagues that the American people are sick and tired of this. They did not like it before. Now they are fed up with it.

We will be hearing more this afternoon.

So, Mr. President, I rise today to raise a point of order under rule XXVIII against H.R. 3288, the Omnibus appropriations bill. I do this to ensure that this bloated legislation is not permitted to proceed to full consideration by the Senate.

Specifically, rule XXVIII precludes conference reports from including policy provisions that were not related to either the House or the Senate version of the legislation as sent to conference. Several provisions included in division D—the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act—of this omnibus bill are out of scope and were never considered on the floor of the Senate.

Mr. President, I raise a point of order that the conference report violates the provisions of rule XXVIII.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Mr. President, I move to waive all applicable sections of rule XXVIII, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

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

The PRESIDING OFFICER. Under rule XXVIII, there is up to 1 hour equally divided.

The Senator from Hawaii.

Mr. INOUYE. Mr. President, I yield myself 10 minutes.

Mr. President, I rise today with mixed emotions. When I assumed the chairmanship of the Appropriations Committee last January, I immediately reached out to the senior Republican member of the committee from Mississippi, Senator COCHRAN, to seek his support in achieving my central objective for the fiscal year: to return this appropriations process to the regular order. The vice chairman, Senator COCHRAN, agreed wholeheartedly, and together we committed to passing all 12 appropriations bills individually and to sending each of the completed bills to the President for his signature.

It might be of interest to my colleagues that of the 12 bills assigned to this committee, 11 were passed by the end of July, many months ago. One was held up at the request of the House but passed in mid-September. This is December. These bills have been passed. And it might be of further interest to the Senate that of the 12 bills, 9 were passed unanimously, bipartisan, 30 to 0. Three passed by one objection—29 to 1.

Completing action on our annual appropriations bills is our most fundamental responsibility. The Founding Fathers gave us the power of the purse, and for good reason. Our system of checks and balances, which has served us so well in the last 220 years, allows the executive branch to propose spending initiatives that make clear to us their intentions and desires. But the Constitution gives the Congress the ultimate decisionmaking authority, and it is our responsibility to fulfill this obligation.

Regular order allows each Senator the opportunity to debate and to amend each bill on an individual basis. Every Senator on both sides of the aisle recognizes that regular order is the preferred course of action.

The underlying Transportation, Housing and Urban Development bill will provide urgently needed funding so we can keep our transportation system safe and strong and provide much-needed assistance to our most vulnerable populations.

In addition, every one of the six bills we consider today was reported out by the full committee. As I pointed out, three of them were passed unanimously and the other three by a vote of 29 to 1. Every one of them has been written in a bipartisan fashion with considerable input on the part of the minority party.

The negotiations with our House counterparts have been spirited at times, but I can assure my colleagues that on the difficult issues, our subcommittee chairmen and ranking members have done an excellent job of defending Senate positions and of coming to fair and equitable compromises when such was necessary.

I would also note that on Tuesday evening, we held a full and open conference with the House at which every conferee, including 22 Members of the Senate, bipartisan Members, and 14 Members of the House, also bipartisan, was afforded the opportunity to offer amendments on any provision of the legislation. For the record, comity was demonstrated by the Senate conferees, and no amendments—no amendments—were offered on our side. At the conclusion of the conference, 16 conferees, including 4 Republican members, signed the conference report.

Finally, I can say this is a clean bill. There are no extraneous measures attached. For this reason, as I just mentioned, we have bipartisan support of the bill, and I am proud of that fact.

Some have criticized this bill as spending too much. I will point out that the amounts recommended in the bill are below the amounts requested by the President and equal to the amount approved by the Congress in the Budget Committee. It has been a long process. Furthermore, the only area where the committee exceeded the amount requested by the President is for military construction and for veterans.

Moreover, some have criticized the majority for resorting to an omnibus measure once again. Clearly, those who criticize are those responsible for this outcome. When the Senate needs 4 days to pass a noncontroversial conference agreement on the Energy and Water appropriations bill, we know the only reason can be that a few Members want to delay our progress. Why do they want to do that? So they can complain when the calendar has expired and we have no time left for the regular order.

As a reminder to all of us, the Military Construction bill was delayed for 6 days of debate on this floor. It was a bill that was voted out of the Appropriations Committee unanimously, bipartisan-wise, and then delayed. But after the delay of 6 days, this Senate passed it by a vote of 100 to 0. What was the opposition all about? What was the delay all about, when everyone here was in favor of it? There was not a single dissenting vote, so it is obvious there was not opposition to the bill. It was simply that a few Members wanted to delay the bill.

Mr. President, now is December 11, and it is nearly time to adjourn the

Senate for the year. We have not completed our work, and therefore we have consolidated six appropriations bills in one measure. My colleagues know precisely why we have reached this point, and it is not the fault of one member of the Appropriations Committee, nor the fault of the majority. It is the fault of a handful of Members who would rather see the responsibility for funding our Federal Government turned over to the bureaucrats and administration than have the Congress exercise its constitutional responsibility. I am a very patient person, but at times the rhetoric of this debate is too much to take.

With Senator COCHRAN, my vice chairman, as my partner, we have tried to move 12 individual bills only to be thwarted by a few Members—just a few Members. That is why we are here and where we are today with an omnibus bill.

As we look ahead to consideration of fiscal year 2011 appropriations bills, I hope all Members of the Senate will learn from the frustrations of this year. We can succeed in returning to regular order for appropriations. We only need a modicum of cooperation and a recognition that delay for the sake of delay serves no one's best interests, least of all the people of the United States.

I strongly support this clean, bipartisan bill. I urge my colleagues to support it as well.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. 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. ENZI. Mr. President, for several weeks I have been saying, where are the appropriations bills? Under Federal law, we are supposed to have those done by October 1—October 1. Let's see. This is December 10. We must be past that deadline.

Well, here come the bills. They are all packed into one. There won't be the debate we would get if we handled them one by one. It is fascinating to me that one of them is Health and Human Services. All year we have heard that health is what is breaking the people of this Nation, how important health care is; why we have to do health care reforms under strict deadlines—strict deadlines that have shifted a number of times and are irrelevant to getting a good bill. But health care is that important, and it is one-sixth of the Nation's economy. So why haven't we had the health care appropriations debate before October 1? Why did it get put off until now? I guess it is because all of the earmarks weren't ready yet or maybe it is because they thought this bill ought to pass and solve all of the problems.

I think the bill could have passed much faster. I think it could have solved a lot more problems. If it would have had the kind of bipartisanship Senator DURBIN keeps describing as having happened, we would already have the bill done. Much of what he keeps repeating—and the more times you repeat it doesn't make it more true—in every speech he gives, he makes the same comments about how long the HELP Committee worked on this bill and how many amendments from the Republican side were automatically accepted into the HELP bill. We always have to come out and correct that. Yes, there were a number of amendments. That bill was put together over a period of 2 weeks with a new committee chairman, without a single input from Republicans. It was brought to the committee for markup. We did have about 3 days to do amendments, and we did a lot of amendments. They did accept some of the amendments. Of course, we helped correct punctuation, we helped correct spelling, and we did have a few amendments that were accepted that actually made a difference.

After the vote, they didn't publish the bill for the public to look at—the amended version of the bill for the public to look at. I think that was so they could rip out the Republican amendments they had accepted. That has never been done in committees. When amendments are accepted, they are left in the bill, or at least the Senator who proposed the amendment gets to talk about why maybe it should or shouldn't be in there, or at least he is informed that they are going to rip it out. Not in this case. The bill is published, we are looking for some of these things and find they are gone. Then they wonder why there is opposition to the bill.

Then he talks about the hours we spent together working as the Group of 6. I appreciate him mentioning the hours, but hours don't make any difference if ideas aren't taken. The purpose of the hours is to be able to express ideas that can be included in a bill. Just getting to express them isn't enough. To make them bipartisan, they have to be included. Anybody who looks at the things we have on our Web sites would understand that we did have some good ideas, some things that would make a change in the way we do health care in America. Are those in this bill? No.

This is the Reid bill. This wasn't put together by the HELP Committee or the Finance Committee, although significant parts of both of those bills, which we didn't have input into, are a part of it. How was that designed? That was designed behind closed doors right over there, with no Republican input whatsoever. How does that make it bipartisan? How does that even give us a chance to make it bipartisan? Then they wonder why we have amendments.

Here is a fascinating thing on amendments: In the HELP Committee, the Democrats presented more amendments than the Republicans did. The Republicans did get two that we voted on and passed. The Democrats had over 30 that they presented to get passed. How come they even had to put in amendments? It was their bill. We are facing the same thing with the bill that is on the floor here. They are putting in more amendments than we are. Every time we put in an amendment they have a side-by-side on it to give them some cover to say, well, what they said wasn't that important. It wouldn't make a difference. Besides that, we don't want to do it, so we will have something that says we voted for that concept.

If you put the bill together, you shouldn't be the ones filibustering and doing the amendments. They have a unique position here now. We have a Democratic amendment and a Democratic side-by-side. I don't remember ever seeing that before. But we had a request this morning for three Democratic votes and one Republican vote. That is real bipartisanship? Yet they want the cooperation.

The thing that upsets me the most is they keep saying this will save money, this bill is going to save the country money, and we are in this appropriations process and we ought to be interested in saving the country money. But CBO didn't say that. CBO did not say that this bill will save money, unless you use a whole bunch of phony accounting, and there is phony accounting in this bill. That is how they are able to say, Oh, yes, we save money. We save money. This is going to save the American people a lot of money. No, it does not. Do not buy that story. Look at the accounting. I am the accountant. I have taken a look at it, but I am not that good of an authority.

We just got the report from the CMS chief actuary. Yes, that is the actuary who is actually in charge of Medicare and Medicaid and he did an analysis on it. I am going to go into some more detail on that analysis, because he says this bill does not save money. This bill will cost seven-tenths of 1 percent more than if we did nothing. Is that health care reform?

And where is the transparency we were promised would happen under this administration? Transparency? They built the bill behind the closed doors over on that side of the Senate Chamber and now a significant part of the bill—which is called the public option, government option, government-run program, whatever you want to call it—has been drastically changed. The newspapers have written about it. People have seen it. But the newspapers haven't seen what is in there. The Democrats, according to Senator DURBIN, the majority whip, have not seen that bill. The only one who has seen it is Senator REID and the Congressional Budget Office. He is not going to disclose any of that—any of that—until after he sees what the score is going to be. That is the ultimate in transparency, in my opinion. If you think

you have a good idea, maybe you ought to let people see what the score is and see what the bill is, and you ought to if you expect us to debate it in a hurry. That is what we are under, this hurry-up situation. Hurry up so a bill that isn't going to do anything until 2014 can be passed by Christmas.

This side is ready to reform health care. This side is ready to stay in through the weekend. We already stayed in through last weekend. We will stay in until Christmas. We will stay in the days after Christmas. We will stay in next year. But it has to be right. The American public expects this to be right.

There has never been a major piece of legislation passed by this body in the history of the United States that was passed by one party. Not yet, there hasn't been. There is a good reason for that. It is full of flaws if just one side's ideas are incorporated in the bill, and this is no exception. This has a lot of flaws. This is a real move to the left to incorporate most of the people over there, but they weren't able to incorporate all of them, so now they are doing a secret public option to expand Medicare to distract people without telling them what is in it and expecting us in a few days to vote on this thing.

Well, I am going to share some of these numbers from the CMS chief actuary a little later, but I see my colleague is here and is actually going to talk mostly on the appropriations bill. I will say that what I have had to say ties in directly to appropriations. It is spending money. We are going to spend $464 billion of Medicare money from a system that is going broke and we are going to raise taxes—that is kind of an appropriation too—to cover the other $½ trillion in new programs that are not going to lower premiums or save the United States money, according to the CMS Chief Actuary Rick Foster.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. DEMINT. Mr. President, I wish to thank Senator ENZI for not just what he said today but for what he has been doing throughout this whole debate to make very complex issues much simpler so that people can listen in to what is being said here and understand what we are doing. It has been a frustrating process here dealing with this attempted government takeover of health care. While the majority has us here on the floor debating one bill, they are behind a closed door over here creating a whole new bill and making periodic announcements about what might be in it. It is kind of like a magician who gets you looking at one hand while the sleight of hand is actually doing the magic with the other hand, and that is what we see happening here today. The majority wants to force this major piece of legislation through before Christmas while people aren't paying attention.

In the middle of this, they have decided to take a break to expand spending at unprecedented levels. I am here right now to support Senator MCCAIN's rule XXVIII point of order that points out that the majority, the Democratic majority, has violated all of these so-called ethics and transparency improvements that they were bragging about only a year ago. We are not supposed to take bills and in the secret of conferences add things that weren't in the House or the Senate version. That violates a specific rule, an ethics rule that the majority trumpeted not too long ago. This bill contains out-of-control spending. It completely reverses Congress's traditional position on many values issues such as taxpayer-funded abortions and needle exchanges in the District of Columbia. It ends the DC Opportunity Scholarship Program that has done so much to help a small number of disadvantaged minority students. It increases funding for Planned Parenthood, the Nation's leading provider of abortions, and it legalizes medical marijuana. Yet the overall funding levels of this bill are unconscionable at a time when we are in recession and so many people are out of work. We have massive debt that threatens our Nation's economic future and our very currency itself.

The bill represents a $50 billion increase or 12.5 percent over last year's funding level. This is not mandated spending; this is discretionary spending. This is a time the President is saying we have to get a handle on our debt. Yet every bill the Democratic majority has pushed across this floor has major increases in spending. It is actually nearly a $90 billion increase over the year before.

Mr. President, what the President said he was against, which was earmarks, this bill has 5,224 earmarks, costing nearly $4 billion, in addition to the other spending. I cannot read all of those, but I think people across the country have learned what earmarks mean. Here are a few examples:

$500,000 for construction of a beach park promenade; six different bike paths totaling $2.11 million; $250,000 for a trail at Wolftrap Center for the Performing Arts; and $250,000 for the Entrepreneurial Center for Horticulture.

I could go on and on. It makes no sense to be doing this. I think maybe one of the most egregious parts of the bill, which I want to focus on for a few minutes, goes back to those values issues. It is one thing to make abortion legal; it is quite another thing to force Americans who consider abortion immoral, based on their beliefs, or religious beliefs—it is immoral to make them pay for it, to actually promote abortion.

That is what this bill does. Everywhere you turn, this administration is promoting anti-life initiatives and advancing policies that most Americans find morally objectionable—namely, taxpayer-funded abortions. We have seen that throughout this health care debate, and now in the very set of bills that funds our government, it is promoting and funding abortion.

This Nation has had a debate about whether we should even allow abortions to be legal. But we have been in general agreement as a nation, and even here in the Congress, for years that we should not force taxpayers to pay for abortions. That is a terrible use of the power of government.

The omnibus bill reported by the House-Senate conference allows taxpayer funds to be used to pay for elective abortion in the District of Columbia, because Congress controls DC's entire budget, including appropriating the city's local revenues. If this omnibus bill passes, Congress will be allowing U.S. taxpayer dollars to fund abortion on demand, when it was previously prohibited.

This is a major shift in policy. We must step back and see where our priorities are as a nation. The values of our country are at stake in this legislation. As we look at this, I hope no American is so naive as to think that if they pass this government takeover of health care, no matter what we put in the legislation, they will eventually fund elective abortions in this country. It shows everywhere they pass a piece of legislation that they are trying to promote abortion in this country.

A vote for the omnibus is a vote for taxpayer-funded abortion. A vote against Senator MCCAIN's point of order is a vote for taxpayer-funded abortion. It is simple and it is clear. Congress is responsible for the budget and the way the funds are spent. If we don't think the government should create an incentive for taking unborn lives, we should not allow it in the legislation before us today.

In addition to this troubling revelation, the bill contains many other egregious reversals of longstanding policy contradicting traditional American values. The underlying bill legalizes medical marijuana and uses Federal funds to establish a needle exchange program in Washington, DC. Both encourage the use of drugs.

This is another glimpse of what is going to happen with government-run health care. If this Congress is promoting the use of medical marijuana, needle exchange programs, abortion, in this funding bill, does anyone believe that that won't be a part of a government-run health care system? Of course not.

Additionally, this bill eliminates the successful DC Scholarship Opportunity Program, which aids low-income children by giving them scholarships to attend private schools in Washington, DC. This affects only about 1,500 children. I have had a chance to meet with some of them who were in schools that were not working. This small scholarship program allows disadvantaged, primarily minority, students in Washington, DC, to go to a private school of their choice. Remarkably, in just a few years, the students who moved from the government schools to the private schools were 2 years ahead of their peers. It is an example of something

that is working, helping disadvantaged students, and it is a good example of an administration that is more interested in paying off union interests—in this case the teachers union—than doing what is good for the children in our country. To eliminate this small, inexpensive program is absurd. But it reveals to you——

Mr. DURBIN. Will the Senator yield for a question?

Mr. DEMINT. No, I won't. It reveals to you the true motives of the majority. If we look at this bill and this eventual health care bill—if we ever have time to see it before they try to pass it—we are beginning to see a real glimpse, a true picture of where this Democratic majority is going.

Finally, this bill increases funding for title X family planning services, of which Planned Parenthood is the largest recipient. Planned Parenthood is the Nation's largest provider of abortions. Increasingly, they are what we call directed abortions. When people come to Planned Parenthood and look for advice on family planning, they are more often than not encouraged and pushed toward abortion.

All around this bill, you see what is going on. It is a major change in policy—not to make abortion available but to make Americans pay for it and to promote it.

I, along with 34 of my colleagues in the Senate, signed and sent a letter to the majority leader regarding the troubling anti-life policies in this omnibus bill. Collectively, we vowed to speak out to protect the longstanding Federal funding limitations on abortion—a belief that has enjoyed broad bipartisan support for many years.

For this reason, as well as a number of other values issues that are irresponsibly addressed in this legislation, I support Senator MCCAIN to raise a point of order against the omnibus under rule XXVIII of the Standing Rules of the Senate. I urge my colleagues to do the same.

I remind my colleagues that a vote against the McCain point of order is a vote to force American taxpayers to promote and pay for abortions. It is plain and simple. I am sure there will be a lot of smoke and mirrors after my talk that will try to convince you that is not true. But it is in the legislation and it will happen. We need to stop it.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I hope the Senator from South Carolina won't leave. He would not yield for a question. I want to address his remarks, and some of them are not accurate. I don't want him to feel that I am saying this outside of his presence.

I ask the Senator from South Carolina, while he has a few minutes, if he could look in the bill and find the provision in the bill that kills the DC Opportunity Scholarship Program. Please present it to me now, because it is not there. It is not there.

The DC Opportunity Scholarship Program is a voucher program, created more than 5 years ago. It was authorized through the Appropriations Committee, not through formal authorization. As many as 1,700 students in DC ended up going to school and getting about $7,500 a year to help pay the tuition for their schools. The program has diminished in size—I will concede that—even though I tried in a debate and negotiations to change that. It is down to about 1,300 students. It is funded in this bill to the tune of $13.2 million.

So for the Senator from South Carolina to stand up and say, as he did, that this program is killed, how does he explain the $13.2 million in the bill?

Mr. DEMINT. If the Senator will yield, the President has said he is going to end this program.

Mr. DURBIN. Does this bill end it?

Mr. DEMINT. I will come to the floor to explain the technical aspects of why it is not.

Mr. DURBIN. I am anxious to hear it. Explain all the technical aspects you would like, but the fact is that $13.2 million goes to the DC Opportunity Scholarship Program. And the 1,300 students currently in the program will be protected and will receive the tuition—a grant of $7,500 per student—in the coming year. That is a fact. To stand there and say otherwise is wrong.

Mr. DEMINT. You grandfather it in—if the Senator will yield for a question, does this bill fund the continuation of the program beyond the 1,300 who are already in it?

Mr. DURBIN. No. It limits the program to 1,300.

Mr. DEMINT. It kills the program then.

Mr. DURBIN. No. If they are why——

Mr. DEMINT. But the program will not continue.

Mr. DURBIN. Reclaiming my time. What happens is this program next year will be up going through the Senate and the House of Representatives. For the Senator from South Carolina to misrepresent the contents of the bill is not fair.

Secondly, this idea of government funding abortion, let me say to the Senator from South Carolina, here are the basic pillars on this controversial issue in America. First, the Supreme Court has said abortion is a legal procedure in Roe v. Wade.

Second, Congress said, through the Hyde amendment, that we will spend no Federal funds for abortion except in cases involving the life of the mother, rape, and incest.

Third, Congress said any provider—hospital, doctor, medical professional—who in good conscience cannot participate in an abortion procedure will never be compelled to do so.

This bill doesn't change that at all. In the Senator's State of South Carolina and in my State of Illinois, the leadership of the States—the Governor and the legislature—decide what they will spend their State funds on. That is done in States across the United States. Seventeen States have decided they will have State funds pay for abortions beyond the Hyde amendment. It is their State's decision, not our decision in DC. We, in this bill, give them the same authority that the State of South Carolina has and the State of Illinois has. No Federal funds from the government, from Congress, can be spent on this exercise or use of funds for abortions beyond the Hyde amendment. But if they choose to use their own funds—just as South Carolina and Illinois make their choice—then they make that decision.

Many in Congress have a secret yearning to be mayors of the District of Columbia. They want to be on the city council—not just in the Senate. They want to make every finite decision for the 500,000 or 600,000 people who live here.

Mr. DEMINT. Will the Senator yield?

Mr. DURBIN. Not at this time. When I finish, I will. The people who live here in DC are taxpaying citizens. They pay their taxes and they vote for President. They send their young men and women off to war just like every State in the Union. I think they are entitled to some of the basic rights we enjoy in each of our own States.

I also want to say a word about the needle exchange program. I get nervous around needles. I don't like to run in to the doctor and say give me another shot. So taking an issue like this on is not a lot of fun to start with. Why are we talking about needle exchange programs in the District of Columbia? For one simple reason: The HIV/AIDS infection rate in the District of Columbia, Washington, DC, the Nation's Capital, is the highest in the Nation. We are living in a city with the highest incidence of needle-related HIV/AIDS and meningitis and other things that follow. A needle exchange program says to those who are addicted: Come to a place where they can at least put you in touch with someone who can counsel you and help move you off your addiction, and they will give you a clean needle instead of a dirty one. I hate it, and I wish we didn't need it. I don't like it. But in States across the Nation they make the decision that this is the humane and thoughtful thing to do to finally bring addicts in before they infect other people and spread this epidemic.

The doctors are the ones who tell us this works. States make the decisions on it. I think the District of Columbia, facing the highest incidence of infection from HIV/AIDS, should also make that same decision in terms of the money they spend. The provision that came over from the House of Representatives would have limited the distribution of this program to virtually a handful of places in DC. We said that DC can make the rules about where the safe places are for these needle exchange programs.

As I said, I hate to even consider the prospect, but I cannot blind myself to

the reality that we have this high incidence of infection in the District of Columbia, and the medical professionals tell us this is working. We are bringing addicts in. We are bringing them into a safer situation. We are counseling some of them beyond their addiction. We are saving lives.

Am I supposed to turn my back on that and say, I am sorry, it offends me to think of this concept? It offends me to think of people dying needlessly, and that is why we have this program.

Let me say a word about the DC Public Schools. I did not ask to take this DC appropriations bill on. This is not something I ran for in the House of Representatives or the Senate. But it is part of my responsibility. This is a great city with great problems, but there are some shining lights on the horizon, and one of them is Michelle Rhee, chancellor of the public school system in the District of Columbia.

Michelle is an amazing story of a young woman attending Cornell University. She decided, when she graduated, to sign up for one of the top employers of college graduates in America today, Teach for America. She went off and taught in Baltimore. She took a hopeless classroom situation and in 2 years turned it around. Kids from the neighborhood had test scores nobody dreamed of because of Michelle's skill. She worked in New York, bringing nontraditional teachers into the teaching situation and then was asked to be chancellor here.

She is working on an overall reform for the DC Public Schools, which I endorse. It is a reform which will move us toward pay for performance, where those teachers who do a good job and improve test scores are rewarded. It is a voluntary program for teachers. The results are starting to show. This week in the District of Columbia, they reported math scores that showed dramatic improvements compared to cities around the Nation.

She has another responsibility: while 45,000 kids are in the public schools of DC, 28,000 are enrolled in public, but independent, charter schools. The charter schools have to match the performance of the public schools or improve upon them. It is the same for the voucher schools, the DC opportunity scholarships.

The Senator from South Carolina stands before us to say I eliminate the program. Where does that $13.2 million go? It goes to the program, the DC opportunity scholarships. I did change the program. I changed the program because I failed initially when I offered amendments.

Here are some of the changes I made, and you be the judge as to whether these are unreasonable changes.

I said for the voucher schools—half of them are Catholic schools—I said for the voucher schools, every teacher in basic core subjects has to have a college degree. How about that for a radical idea, a teacher with a college degree? It is now required. It was not before.

Second, the buildings they teach in—these DC voucher schools have to pass the fire safety code. Is that a radical idea killing the program? If it means closing a school that is dangerous, sure, I would close that school in a second before I would send my child or grandchild there.

Third, we said, if you attend a DC voucher school, the students there have to take the same tests as the DC Public Schools so we can compare how you are doing. If you take a different test, you have different results. We are never going to have a true comparison.

I also added in here, at the suggestion of Senator LAMAR ALEXANDER of Tennessee, a former Secretary of Education, that each of the DC voucher schools either has to be accredited or seeking accreditation. I don't think that is radical. I don't think it closes a program.

The final thing I say is, the people who administer this program have to actually physically visit the school at least twice a year. We had a hearing where the administrator of the program was shown pictures of some of these DC voucher schools and, frankly, he said: We have not been there. Maybe once a year we get by. It has to be more than that. We have to make sure these schools are functioning and operating. We are sending millions of Federal dollars into them. We expect it at public schools, we expect it at charter schools. Should we not ask the same of the DC voucher schools?

I say this, at least those in the Archdiocese of Washington agreed to these things and have said: For our Catholic schools, we are ready to meet these standards and tests. My hat is off to them. It is a challenge, I am sure, but it is one I think they will meet. I want them to continue to do that.

I did try to expand this program in one aspect in the course of our negotiations, with Senator COLLINS' assistance, so siblings would be allowed to attend this program. I think it would be helpful. We were not successful. There are those opposed to this altogether.

I say the Senator from South Carolina has mischaracterized the DC voucher program. He has not fully explained that we have not changed the Hyde amendment, which prohibits Federal funds for abortion purposes, other than strict narrow categories. He went on to say something about the needle exchange program, which does not reflect the reality and the gravity of the health crisis facing the District of Columbia.

This is not a radical bill. This is a bill which I think is in the mainstream of America. It is a bill consistent with the same laws that apply in his State of South Carolina and my State of Illinois and most other States across the Nation.

I wish we were not in this paternalistic position in relation to the District of Columbia. I would rather this city had home rule, had its own Members of Congress, could make its own decisions. That is my goal. I would like to see that happen. In the meantime, I think we should treat the people who live here fairly, give them a chance to deal with their significant problems, acknowledge success, as we just reported in the public schools, and try to help them where we can.

This is, in fact, a great city and the capital of a great nation. I think the mayor does a good job.

I reserve the remainder of my time.

Mr. ENZI. Mr. President, what is the time situation?

The PRESIDING OFFICER. The Senator from Wyoming has 8 minutes 26 seconds. The Democrats have 7 minutes 30 seconds.

Mr. ENZI. Mr. President, I rise to discuss a new report on Senator REID's health care reform bill. This kind of fits in with the appropriations that deal with Health and Human Services that is over 2 months past due.

Last night, we received a new analysis of the Reid bill we have been discussing about 11 days straight, performed by the Center for Medicare and Medicaid Services—that is CMS—which is under the Department of Health and Human Services. The chief actuary, Rick Foster—this is the guy in charge of all this. He is the chief actuary. This is not somebody outside the system. This is the guy who has to answer for all this. He serves as the independent technical adviser to the administration and Congress on estimating the true costs of health care reform. Some of the findings in this report directly contradict some of the claims we heard this week about the Reid bill.

For a week now, we have heard how the Reid bill will help slow spending growth and reduce how much we as a nation spend on health care. Mr. Foster's analysis shows that statement is false.

According to this report, national health expenditures will actually increase by seven-tenths of 1 percent over the next 10 years. That is seven-tenths of 1 percent if we did nothing different. Despite promises that the bill would reduce health care spending growth, this report shows the Reid bill actually bends the health care cost curve upward.

We have also heard, over the past week, how this bill will reduce health insurance premiums. Again, the administration's own chief actuary says this is false. The new report describes how the fees for drugs, devices, and insurance plans in the Reid bill will increase health insurance premiums, increasing national health expenditures by approximately $11 billion per year.

We have also heard how the Reid bill will reduce the deficit, extend the solvency of the Medicare trust fund, and reduce beneficiary premiums. According to the Foster report, these claims are all conditioned on the continued application of the productivity payment cuts in the bill which the actuary found were unlikely to be sustainable

on a permanent annual basis. If these cuts cannot be sustained, one of two things will happen. Either this bill will dramatically increase the deficit or beneficiaries will not be able to continue to see their current doctors and other health care providers.

In reviewing the $464 billion in Medicare cuts in the Reid bill, the Foster report found these cuts would result in providers finding it difficult to remain profitable.

The report went on to note that absent legislative intervention, these providers might end their participation in the Medicare Program. In addition, if enacted, the report found that the cuts would result in roughly 20 percent of all Part A providers—that is hospitals, nursing homes, et cetera—becoming unprofitable within the next 10 years as a result of these cuts.

As a former small business owner myself, I understand the impact this will have on doctors, hospitals, and other health care providers. In rural areas, such as my State, these providers will go out of business or have to refuse to take any more Medicare patients.

The CMS actuary noted that the Medicare cuts in the bill could jeopardize Medicare beneficiaries' access to care. He said the Reid bill is especially likely to result in providers being unwilling to treat Medicare and Medicaid patients. That is what we have been saying for about 11 days.

The Reid bill also forces 18 million people into the Medicaid Program. The Foster report concluded this will mean a significant portion of the increased demand for Medicaid services will be difficult to meet. These are not the claims made by insurance companies or anyone who might have a vested interest in the outcome of the debate. These come directly from the administration's own independent actuary.

In light of this report, why are the sponsors of this bill continuing to argue for a $2.5 trillion bill of new programs which will increase health care spending, drive up premiums, and threaten the health care of Medicare beneficiaries?

We can do better. We need to start over and develop a bipartisan bill that will address the real concerns of American people—develop a bipartisan bill. They cannot just exclude one side because there is a majority that won the election and gets to write the bills. We get tired of hearing that told to us. Where is your comparable bill? We are not trying to have a comparable bill, we are trying to have input into the current bill or the current bills: Sit down, talk about the principles, find the actual things that fit into those principles, develop the details, and have a bill that goes step by step so we get the confidence of the American people. The step we ought to start with is Medicare. That is why I present this report from the actuary of CMS, which is part of the Department of Health and Human Services, which is assigned most of the job of coming up with the details of the bill we have before us. That means actual elected officials would not be doing it. But this CMS actuary says everything that has been said by that side of the aisle is false unless there is some phony accounting that goes into it.

I yield the floor and reserve the remainder of our time.

Mr. President, I suggest the absence of a quorum and ask unanimous consent that we divide the time.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mrs. MURRAY. Mr. President, 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. LEAHY. 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. LEAHY. Mr. President, Division F of this omnibus conference agreement provides funding for the State Department, Foreign Operations, and related programs.

I want to thank the ranking member of the subcommittee, Senator GREGG, and his very capable staff, Paul Grove and Michele Wymer, for once again working with me and my staff in a bipartisan manner to produce this conference agreement.

I also want to thank Chairwoman NITA LOWEY and Ranking Member KAY GRANGER, and their staffs, for working so cooperatively with us throughout this process.

The fiscal year 2010 State Foreign Operations conference agreement provides $48.8 billion in discretionary funding, a $3.3 billion decrease from the President's budget request of $52 billion.

The bill is $1.2 billion below the fiscal year 2009 level, including supplemental funds. This is an important point that needs to be understood by all Senators, because yesterday a Senator on the other side of the aisle criticized this bill for being 31 percent above fiscal year 2009.

That is misleading, because it does not account for the billions of dollars in fiscal year 2009 ''emergency'' supplemental funding that was the standard way of doing business under the previous administration.

To ignore those costs to American taxpayers is disingenuous. President Obama has made clear that he intends to fund these programs on budget, not through supplemental gimmicks. That is what the Congress urged him to do, and now he is being criticized for doing so.

If you compare apples to apples, this bill provides $1.2 billion less spending than in fiscal year 2009.

Some Republican Senators have made speeches against this omnibus package on account of earmarks they don't like, even though some of them requested their own earmarks. In fact, earmarks comprise a tiny fraction of the total package.

Like past years, the State-Foreign Operations conference agreement does not contain any earmarks as defined by the Appropriations Committee.

We do fund many programs that are priorities of Democrats and Republicans, including assistance for countries like Afghanistan, Pakistan and Iraq, and longstanding allies like Israel, Egypt, and Jordan.

In addition, the conference agreement provides $5.7 billion to combat HIV/AIDS, including $750 million for the Global Fund. Funds are provided to combat other diseases, like malaria, tuberculosis, and neglected tropical diseases,

The agreement provides $1.2 billion for climate change and environment programs, including for clean energy programs and to protect forests.

The agreement provides $1.2 billion for agriculture and food security programs, with authority to provide additional funds.

There are provisions dealing with corruption and human rights, funding for international organizations like the United Nations, NATO and the International Atomic Energy Agency, and to promote democracy, economic development, and the rule of law from Central America to Central Asia.

The conference agreement provides the funds to support our embassies and diplomats around the world, public diplomacy and broadcasting programs, the Peace Corps, and many other programs that promote United States interests.

I don't support everything in this omnibus package any more than anyone else does. I had hoped, as I know did Chairman INOUYE and Vice Chairman COCHRAN, that we could have brought each of the bills in this omnibus, including the State-Foreign Operations bill, to the Senate floor individually.

But a handful of Senators on the other side have made clear that they will do whatever is procedurally possible to slow down or prevent consideration of these bills.

Despite that, I can say that the State Foreign Operations conference agreement was negotiated with the full participation of both House and Senate chairmen and ranking members. It was in every sense a collaborative process.

It is a balanced agreement and should be supported by every Senator who cares about U.S. security and the security of our allies and friends around the world.

The PRESIDING OFFICER. The question occurs on agreeing to the motion to waive all applicable sections of

rule XXVIII. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. KYL. The following Senators are necessarily absent: the Senator from Kentucky (Mr. BUNNING), the Senator from Oklahoma (Mr. COBURN), the Senator from Texas (Mrs. HUTCHISON), and the Senator from North Carolina (Mr. BURR).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''Nay.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 36, as follows:

[Rollcall Vote No. 372 Leg.]

YEAS—60

Akaka	Feinstein	Mikulski
Baucus	Franken	Murray
Begich	Gillibrand	Nelson (NE)
Bennet	Hagan	Nelson (FL)
Bingaman	Harkin	Pryor
Bond	Inouye	Reed
Boxer	Johnson	Reid
Brown	Kaufman	Rockefeller
Burris	Kerry	Sanders
Byrd	Kirk	Schumer
Cantwell	Klobuchar	Shaheen
Cardin	Kohl	Specter
Carper	Landrieu	Stabenow
Casey	Lautenberg	Tester
Cochran	Leahy	Udall (CO)
Collins	Levin	Udall (NM)
Conrad	Lieberman	Warner
Dodd	Lincoln	Webb
Dorgan	Menendez	Whitehouse
Durbin	Merkley	Wyden

NAYS—36

Alexander	Feingold	McCaskill
Barrasso	Graham	McConnell
Bayh	Grassley	Murkowski
Bennett	Gregg	Risch
Brownback	Hatch	Roberts
Chambliss	Inhofe	Sessions
Corker	Isakson	Shelby
Cornyn	Johanns	Snowe
Crapo	Kyl	Thune
DeMint	LeMieux	Vitter
Ensign	Lugar	Voinovich
Enzi	McCain	Wicker

NOT VOTING—4

Bunning	Coburn
Burr	Hutchison

The PRESIDING OFFICER. The yeas are 60, the nays are 36. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

Mr. LEAHY. Mr. President, I move to reconsider the vote.

Mrs. MURRAY. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. I ask unanimous consent that no further points of order be in order during the pendency of H.R. 3288.

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

Mr. REID. It is my understanding that the next vote will be tomorrow morning at 9:30. We will be happy to come in at 8:30, but I ask unanimous consent if we could have that vote at 9:30. We will come in at 9, if that is OK with everybody.

Mr. MCCAIN. Will the majority leader yield for a question?

Mr. REID. I am happy to.

Mr. MCCAIN. And the disposition of the pending Dorgan amendment, could we have some idea about that?

Mr. REID. I think my friend from Arizona asks a very pertinent question. We offered a consent request last evening—and I did again today—that we would have the votes now before the Senate in sequential order. I offered a unanimous consent request to do that. We are happy to do that. I announced there would be no more votes today. On Monday when we come in, we will be happy to do that.

Mr. MCCONNELL. I say to my friend the majority leader, the problem with that is we have been going back and forth with an amendment on each side, and the agreement that you have proffered, if I understand it correctly, basically had two Democratic side-by-sides. Am I not correct in my understanding of that?

Mr. REID. Yes, but on all amendments that we have had up to this point, every side, Democrats or Republicans, has had the opportunity to do side-by-sides if they wanted to. In the weeks we have worked on this, what has transpired here, I am quite sure, has happened before. Simply stated, we have been requested by Republicans to have some votes, and we have agreed to have the votes. I explained in some detail last evening why we can't do it on a piecemeal basis. Procedurally, it puts us into a quagmire. Let's clear the deck. There will be other amendments after that we would certainly try to have each side offer.

But I agree with the Senator from Arizona, we should get rid of the drug reimportation amendment one way or the other, in addition to the motion offered by Senator CRAPO.

Mr. MCCONNELL. My point was, typically a side-by-side is offered one on each side. On the drug reimportation issue, you have basically two votes, both generated on the Democratic side, which created some confusion. But we will have to continue to talk about this and see if we can work our way through it.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Mr. President, I wanted to ask the minority leader—some of us are a little bit perplexed. I know the Senate has its rules, and we try to work through them. But we also at this time of year often try to accommodate families and schedules and so forth. I am curious as to whether the minority leader might not consent to allowing us or why it is that we couldn't, since Senators are here today, schedule the vote and agree to have the vote on the 60-vote margin today rather than tomorrow morning, requiring all staff and everybody in the Senate to come in on a Saturday.

Mr. REID. If I could make a comment before my friend the Republican leader comments, everyone should understand—this should make it easier for everybody—I am going to be home all weekend in Washington. I won't be traveling the country doing any fundraisers that people seem to be afraid of.

Mr. MCCONNELL. The answer to it is that our good friend the majority leader told us on November 30 we would be here the next two weekends. He said again this past Monday we would be here this weekend. I assumed and I know he certainly meant what he said. Our Members are here and ready to work. We wish to work on health care amendments. But as a result of the privileged status of the conference report that is before us, we have had that displaced. But I think everybody was on full notice as to what the work schedule was going to be for last weekend and this weekend.

Mr. KERRY. Mr. President, if I could respond, I don't mean to assert myself in any way that is inappropriate with respect to the leader, but we all know that in the workings of the Senate, what we are doing is both complicated and serious and critical to the country.

We are waiting for CBO to appropriately, consistently—as a member of the Finance Committee, we adhered to a very strict notion that we would try to find the precise modeling and cost of whatever it was we might do. It is entirely appropriate, to have a proper debate or discussion, that we know exactly what the cost is of any particular proposal. That is what we are waiting for. So the majority leader is appropriately trying to move another piece of legislation that is ripe, that is important to the country. This is just a question of courtesy to Senators and to their families and to the staff of the Senate who have been working extraordinarily hard. The question is simply, why, as a matter of convenience, we couldn't schedule a vote for today instead of being scheduled for tomorrow. We could do that by unanimous consent.

Mr. REID. If I could have the RECORD reflect, the Republican leader is right. I said we would be in session the next several weekends. But if you go back and look at the RECORD, how many times have I said we would be in session over the weekend and, interestingly enough, around here, magic things happen on Thursdays and Fridays. I have had every intention, as I have every time I have said it, that we should be in on a weekend, and usually we are able to work something out. We haven't been able to this time. I accept that. I am not complaining. But certainly the question of my friend from Massachusetts is a pertinent one. Senators are here now. Maybe we could have the vote early. But it is set statutorily. My unanimous consent request was, and I am not sure it was responded to, that we could have that vote at 9:30 tomorrow morning without having the mandatory 1-hour beforehand.

I heard no objection to that. We will just come in at 8:30. We will come in at 8:30 tomorrow morning and have a 9:30 vote.

Mr. KERRY. Mr. President, I ask unanimous consent that the vote

scheduled for tomorrow morning be held instead today at some convenient time within the next hours.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object—and I will object—we have been told by the majority that the single most important thing we could do would be to work on weekends and try to pass this health care bill which, according to the CNN poll that came out last night, the American people oppose 61 to 36, before Christmas. We are here. We are prepared to work. We would like to get back on the health care bill as rapidly as possible and vote on amendments to the bill. It either is or it isn't important enough for us to be here before Christmas. My Members are not expecting to take a break. We have been told by the majority all year long this is important. First we had to get it done before August. Then we had to get it done before Thanksgiving. Now we have to get it done before Christmas. We are here, ready to work.

I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from New Hampshire.

Mr. GREGG. Is the Senator from Arkansas seeking recognition?

Mrs. LINCOLN. Yes.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. GREGG. Mr. President, I still have the floor. I was just asking a question.

The PRESIDING OFFICER. The Senator from New Hampshire has the floor.

Mr. GREGG. Mr. President, I ask unanimous consent to be allowed to speak for up to 10 minutes and then that the Senator from Arkansas be recognized, and then we will come back to this side.

The PRESIDING OFFICER. Is there objection?

The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, reserving the right to object—and I have no intention of objecting—I would like to also propound a unanimous consent request that after the Senator from Arkansas has spoken and after the Senator from New Hampshire has spoken, Senator COLLINS, I, and Senator BAYH be recognized for up to 30 minutes for a colloquy.

The PRESIDING OFFICER. Is there objection to the request of the Senator from Oregon?

The majority leader is recognized.

Mr. REID. Mr. President, reserving the right to object, I would ask my friend from Oregon if he would allow this modification to his unanimous consent request. It would be as follows: consent that Senator LINCOLN be recognized and that she be allowed to speak for up to 10 minutes; that Senator GREGG be recognized for up to 10 minutes; and then that Senators WYDEN, COLLINS, and BAYH be permitted to engage in a colloquy for up to 30 minutes; that following the conclusion of that 30 minutes, Senator ALEXANDER or his designee be recognized for up to 30 minutes to engage in a colloquy with other members of the Republican caucus.

The PRESIDING OFFICER. Is there objection?

The Senator from New Hampshire.

Mr. GREGG. Mr. President, reserving the right to object, I understand that is in addition to Senator WYDEN's request, which is that I should begin with my first 10 minutes, then we would go to the Senator from Arkansas, then we would go to Senator WYDEN, and then we would go to the outline as represented by the majority leader.

Mr. REID. If that is OK with the Senator from Arkansas.

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

The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, thank you very much.

Mr. President, I rise to speak a little bit about this health care bill. I know there has been a lot of discussion of it already today, but I think it is important—very important—that as this health care bill comes forward, we know what it says.

Unfortunately, we received this 2,074-page health care bill about 8 days ago, after it had been worked on for 8 weeks in camera, behind closed doors by the Democratic leadership. We have only had 8 days to look at it. We now hear there is going to be a massive revision of it—a massive revision—that is going to involve potentially expanding Medicare to people who are aged 55.

Medicare is already broke, by the way. It is broke. It has a $38 trillion unfunded liability. And we are going to add another 10 million people, maybe, into Medicare? That makes no sense at all.

But what I think is important is that what we know so far has been reviewed by a lot of different people, but some of them have not been all that objective. So there was a request made to CMS, which is an arm of the administration—therefore, one would presume it was not necessarily biased toward the Republican side of the aisle; in fact, maybe just the opposite; I do not think it is biased at all, hopefully; but if there was bias here, it certainly would not be Republican—to review the proposal of Senator REID.

Let me read to you what the CMS conclusion is—some of them—on the Reid bill.

According to the CMS Actuary: ''The Reid bill increases National Health Expenditures'' by $234 billion during the period 2010 to 2019. Why is this important? Well, it is pretty darn important because we had representations that the purpose of this health care reform was to decrease, to move down, health care costs. Now we find this bill, as scored by the CMS Actuary, significantly increases the national health care expenditures.

Secondly, they concluded that ''the Reid bill still leaves an estimated 24 million people . . . uninsured.'' Twenty-four million people—that is almost half of the uninsured today. Why is that important? We were told the purpose of this health reform exercise was to, one, insure everybody; two, bend the health care costs down; and three, make sure that if you have your own health care that you like, you do not lose it. Well, on two counts, it appears the Reid bill clearly fails that test and gets an F—on the issue of bending health care costs down and on the issue of insuring everyone, according to CMS, an independent group.

Third, it says:

> The new fees for drugs, devices, and insurance plans in the Reid bill will increase—

Increase—

> prices and health insurance premium costs for customers. This will increase national health [care] expenditures by approximately $11 billion per year.

So instead of bringing health premiums down, as was represented by the President—he said it was going to go down by $2,100 per family—your health care premiums are going to go up. What happens when health care premiums go up? People stop giving you health care insurance because they cannot afford it. Employers cannot afford it. So on the third issue, will you lose your health insurance if you like it, yes, you will. Yes, you will because the price of your health insurance is going to go up under the Reid bill.

There are a couple other points they make which are fairly important here:

> The actuary's analysis shows that claims that the Reid bill extends the solvency are shaky.

They are ''shaky''—the claims that it extends the Medicare trust fund solvency.

Quoting further:

> Moreover, claims that the Reid bill extends the Medicare HI Trust Fund and reduces beneficiary premiums are conditioned on the continued application of the productivity payment adjustments in the bill, which the actuary found were unlikely—

That is their concept, ''unlikely''—

> to be sustainable on a permanent annual basis. . . .

So the idea that this bill somehow assists Medicare—by the way, this bill cuts Medicare by $½ trillion, almost, in the first 10 years. When it is fully implemented, it cuts Medicare by $1 trillion in a 10-year timeframe, and over the next 20 years, it cuts Medicare by $3 trillion. The idea that this is going to somehow help Medicare is fraudulent on its face, according to the Actuary. ''Fraudulent on its face'' is my term. It is ''unlikely'' to accomplish that.

Then it goes into this issue of the CLASS Act, which we have heard so much puffery about how wonderful this CLASS Act is, which is basically another Ponzi scheme, as it was described by the chairman of the Budget Committee, not myself. The Actuary said:

> The Reid bill creates a new long term insurance program (CLASS Act) that the CMS actuaries found faces ''a very serious risk''—

This is their term, ''a very serious risk''—

of becoming unsustainable as a result of adverse selection by participants. . . .

In other words, only people who are probably going to need long-term care are going to opt into this program. So this plan will basically not be able to pay the costs of the benefits it is proposing because they will not have funds coming in to support the people who need it because there will be no larger insurance pool of healthy people who are using the program. Only the people who need the program will use it. So the CLASS Act representations we have heard around here have been debunked by this CMS report.

This is not our side saying these things. It is not our side saying that the cost of this bill will drive up the cost of national health care. It is not our side saying there are 24 million people left uninsured when this is fully implemented. It is not our side saying premiums will go up when this bill is fully implemented. It is not our side saying the CLASS Act will be a seriously unsustainable program. It is not our side saying Medicare will not be benefited by this program. In fact, it will be negatively impacted by this program. It is CMS saying that, an independent Actuary—not that independent; an arm of the administration. The administration's Actuary is saying it, not our side. So I think it is legitimate to have some serious concerns about this bill.

The CMS report goes on and says:

The CMS actuary noted that the Medicare cuts in the bill could jeopardize Medicare beneficiaries' access to care.

Now, that is serious. That is serious.

It found that roughly 20 percent of all Part A providers—hospitals—would become unprofitable—20 percent of all Part A providers, such as hospitals, would become unprofitable within the next 10 years as a result of the proposals in the Reid bill.

Well, I know ''profits'' is a bad word on the other side of the aisle, but the simple fact is, if you do not have profit in a hospital, the odds are pretty good you are going to go out of business. You are going to go out of business because you cannot pay the costs of operating that hospital. Even nonprofits have some sort of cushion in order to make it through. Now we have the CMS Actuary telling us that 20 percent of the hospitals in this country are going to go into a negative cashflow and are going to become unprofitable as a result of what this bill proposes.

Well, colleagues, Senators, why would we vote for a bill which increases the cost of health care for the country and does not bend the health care cost down, which leaves half the people in this country who are uninsured still uninsured, which raises the premium costs for Americans, which puts the Medicare system at risk, which will put hundreds of providers at risk, hospitals, and which creates a brandnew entitlement which is not sustainable? And those conclusions are come to by the CMS, the independent CMS Actuary. Why would we want to put that type of program in place? Of course, we should not.

Listen, this 2,074 pages of bill—it was put together haphazardly. It was just sheets of paper stuck together. It ends up costing us $2.5 trillion overall. Every page costs us about $1 billion. Obviously, it was not well thought out because the CMS Actuary looked at it and said it is not well thought out. It does not accomplish its goals.

So rather than moving forward with the bill, why don't we just step back and start doing things we know are going to work? Why don't we start doing a few things around here we know are going to work?

I know the Senator from Oregon is on the floor, and he happens to be the sponsor of a bill which actually would make some progress in the area. Why don't we—I would be willing to step back and start from his bill because his bill at least makes sense. If it were scored by the CMS Actuary, it would not come out like this. They would not be saying that people would be uninsured, that the price of health care was going to go up and that Medicare was going to go into a disastrous strait and create an unsustainable entitlement.

So we have ideas around here that do work or are fairly close or at least have the foundation to work. Why don't we use those rather than this bill? That is my only point. This bill is ill thought out, and that is not my conclusion, that is the only conclusion you can come to when you look at the CMS Actuary's evaluation of it.

Mr. President, I appreciate the courtesy of the Presiding Officer, and I especially appreciate the courtesies of the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. Mr. President, thank you. And I appreciate the courtesies of my colleague from Oregon for allowing me to speak now.

I rise today to talk a little bit about the health care concerns, particularly, in our small businesses. I first wish to compliment and thank my colleagues, particularly Senator LANDRIEU, who is chairman of the Small Business Committee, as well as Senator SNOWE, with whom I have worked for years on the plight of the small businesses in our States and across the country—their need to be able to really access the kinds of competition and choice that allow them to make good decisions and spend their health care dollars more wisely and being able to do what they all want to do in small business, and that is to be able to cover their employees, to make sure their employees and their employees' families are covered with reasonable and meaningful health insurance that actually covers what they need but is at an affordable price. So I thank those women, as well as Senator STABENOW, who I know has also been working on these issues.

But I really come to the floor today to highlight the challenges Arkansas small business owners face in providing quality, affordable health care for themselves, their families, and their employees under the current system and to look at what we can do to improve what their challenges are, what it is they face.

Small businesses are our No. 1 source of jobs in Arkansas, and they are truly the economic engines of our local economies, but they are also the economic engines of our national economy, not to mention learning laboratories for great ideas that will allow us in this great Nation to be truly competitive in the 21st century.

Arkansas's nearly 250,000 small business and self-employed individuals make significant contributions to our State's economy and generated $7.2 billion in 2008. Small employers account for 97 percent of the employers in our State, and I would daresay nationally it is somewhere at that same level.

Addressing the needs of small businesses is absolutely critical to any health insurance reform legislation we bring forward.

As I mentioned before, Senator SNOWE and I have worked together for many years to try to address these concerns, talking with small businesses and their advocacy groups to try to figure out what it is we can provide them, just as we provide ourselves as Federal employees the ability to access health insurance that has been negotiated, where people have come together, pooled the resources of all of our risks as Federal employees—all 8 million of us—to really get a better deal in the marketplace.

We want to be able to allow small businesses to do the same, to come together nationwide, pool themselves in their State exchanges, and be able to really take advantage of sharing their assets and their risks in the health insurance marketplace and get the best possible product they can.

Those small businesses that are able to afford health care coverage for their employees in today's world continue to experience skyrocketing costs, jeopardizing our States' and our Nation's competitive edge, both among themselves nationwide domestically but also internationally. We find that our small businesses are finding themselves more and more in the situation of having to be competitive globally to be able to do the business they do and to create the jobs they need to create.

Yesterday, I spoke with a radio station owner from Wynne, AR, in Cross County, who said high costs have threatened his ability to be able to provide coverage for his employees. Or, worse, skyrocketing costs are forcing business owners to consider giving up their businesses altogether, like the small business owner from Malvern, AR, who wrote me that he was giving up his 17-year-old business because he can no longer afford his rising health care insurance premiums. His wife and

his daughter each have a preexisting medical condition, and he feels pressured to find a new job that provides affordable employer-sponsored coverage for his family.

I heard from another small business owner in Mena who told me that at the age of 65, he continued to keep himself on his own small business's health insurance plan in order to ensure that he could maintain providing health insurance to his employees, many with whom he grew up. They were friends of his from grade school or church and community services and other places where he had built lifelong relationships, not only as an employer and an employee but as part of a community. Being able to maintain providing that to them was so critical to him that he was willing to ante up.

I have heard from small business owners from all across my State who desperately want to offer health care coverage for their employees, but it is simply not cost productive. The fact is, so many people think small businesses just want to opt out, that they don't want to provide health insurance, but they do. They do because it is important to them as a part of that community to do something for their employees who also happen to be their friends and neighbors. They also want to make sure their business is the best it can be, and in order to do that they have to compete for those skilled workers. Getting the best workers means providing good benefits, with health care being at the top of that list.

Another Arkansan asked me to please include the self-employed in my efforts to secure affordable health care. There are many small businesses with only one employee, and health care under this scenario is extremely expensive. They are put in an individual market where they are rated against themselves in many instances and not given the benefit of what we enjoy as Federal employees; that is, pooling ourselves together, adding our assets and our risks together so that we can mitigate that risk among all 8 million Federal employees.

These are just a few of the stories I have heard from Arkansans, and that is why in every Congress since 2004, I have introduced legislation to help small business owners afford health coverage for themselves, their employees, and their families. Several of my provisions are already included in the health insurance reform bill currently before the Senate, including the tax credit to help small businesses afford coverage, and we want to improve upon that. Also included are insurance exchanges through which consumers can compare insurance plans side by side so that they will be able to choose the option that is best for them, allowing their employees to see what is available to them and making sure that they are having access to all the options of the marketplace. There are reforms that force insurance companies to change the way they do business by limiting what an insurer can charge based on age and by banning the practices of denying coverage based on preexisting conditions or increasing rates when customers all of a sudden get sick.

We look at our small businesses and, yes, there are a lot of young entrepreneurs, but a lot of our small businesses are those individuals in that category above 55. These are people who, unfortunately, are starting to see chronic disease challenges in their life as they age. Unfortunately, they become an issue, or certainly their coverage becomes an issue when we talk about preexisting conditions. So it is critical that we make sure we change the way insurers do business as usual today and make sure they are playing fair with the small business entities out there.

Just one more of my efforts is something on which we worked with Senator SNOWE and Senator DURBIN, which is to allow that there would be national private insurers, as there are today, but allowing them to sell multistate plans nationwide, to be able to sell their plans in all 50 States. It would be with a strong Federal administrator who would be able to negotiate for quality and affordable coverage. Some of this has emerged as another potential part of the framework for national health insurance reform that can help us achieve our goals of more choices and more affordability for consumers, particularly those in the small business marketplace.

So I wish to thank the Presiding Officer for the opportunity to share with my colleagues and certainly those Americans out there who are the ingenuity and the engine of our economy. I know my colleague from Oregon has talked so much about choice and competition. It is so important, more important than ever in that small business marketplace and in that individual marketplace, as well as providing exchanges and the ability for national insurers, private insurers to be able to provide these types of products across all 50 States. Also, a multistate plan gives our small businesses and our self-employed, our individual marketplace, our independent contractors, such as our realtors and others, the ability to have access to greater choice, greater competition in that marketplace, and, therefore, a better product—greater, more meaningful coverage at a more reasonable cost, and that is what we want to see. More importantly, that is what our small businesses want to see.

So I thank the Presiding Officer, and I yield the floor to my colleague from Oregon and my colleague from Indiana, and the Senator from Maine as well, whom I know will have a great addition to this conversation. Thank you.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from Indiana.

Mr. BAYH. Madam President, I wish to begin by complimenting my friend and colleague from Arkansas. We entered this body together, and she has consistently advocated on behalf of small businesses, not only across Arkansas but across the country. We both want to reform the health care system. We know this has a major impact on small businesses. They create most of the new jobs in our society. So if we care about job creation, we need to care about how health insurance costs affect businesses. They are going up too fast, and Senator LINCOLN has consistently advocated for doing what we can to get those cost increases down and, in fact, lower the burden on our small businesses. So this is not only a health issue, it is a jobs issue. She has been a real leader for many years.

So it is a privilege to work with the Senator on these important issues. Our class is doing well.

I also wish to say how much I am privileged to work with my friend from Oregon, Senator WYDEN, who has been one of the most innovative thinkers in the area of health reform. Once again, he is leading the way on an issue I am going to speak to for just a second.

I am happy to see my colleague from Maine is with us. It saddens me to say that, regrettably, this is one of the few examples of bipartisan cooperation where we have come together across the aisle, Democrats and Republicans, working together to figure out how in a practical way we can help solve the problem our country faces.

Here we have an issue of what to do about the 7 percent of Americans who are the individual insurance market but are receiving no subsidies from the government. According to the CBO, they are at risk of having their premiums go up. That is not right, particularly at a time when even people who are making more than $88,000 very often are struggling. So the question is, What can we do about it?

Senator COLLINS, Senator WYDEN, and myself focused on these individuals because we wanted to do what we could, in the words that my colleague from Oregon emphasizes so often, to provide choice and encourage competition to improve both price and quality. That is what our amendments are all about.

I wish to read a very brief statement and then turn it over to my colleagues.

When I go home to Indiana, the health care concern I hear the most about from ordinary Hoosiers, particularly middle-class Hoosiers, is what are we going to do to make their coverage more affordable. Many people in my State already have insurance, but they are struggling to keep up with the skyrocketing increases and the cost of that care.

We began our health care debate and these deliberations in this body this past spring. In mid-October, months into our debate, some of us were struck by the fact that we had not answered the most basic question: How much is this going to cost, and what do we do to bring those costs down? So I, along with some others, submitted in writing

that question to the Congressional Budget Office. What will this do for people in the small group markets such as small business owners, what will this do for individuals in the large group markets who work for larger employers, and what will it do for individuals who are out there struggling on their own to provide health insurance for themselves and for their loved ones?

When they released their report, I was pleased to see that the current legislation before us would either contain or lower costs for 93 percent of the American people. For 83 percent of those in small group and large group plans, it is about holding even or modestly lower. For the 17 percent in the individual marketplace, about 10 of that 17 percent get subsidies sufficient to actually bring their prices down, which leaves us with the 7 percent of those individuals in the individual market who get no subsidies and may see serious cost increases if nothing is done. The Wyden-Collins-Bayh amendments accomplish just that.

Our first amendment promotes more health choices for both employers and workers who would otherwise have few, if any, choices. It would help individuals who would be forced to buy their own insurance at higher rates than they currently pay. It would give them the option to purchase low-cost plans that offer essential, basic coverage. It would ensure that Congress does not mandate that anyone buy a more expensive plan than they currently have.

Our second amendment is a market-based reform that would pressure insurance companies economically to lower premiums and penalize them if they try to raise rates before the new exchanges are fully up and running. It would immediately adjust the insurer fee in the bill to give insurance companies a strong financial incentive to keep premiums down. It would do this by making it economically smart for companies to hold the line on overhead and executive salaries and to root out administrative inefficiencies.

Our third amendment would offer vouchers to give consumers who have health insurance but aren't satisfied with it access to more choices to meet their health care needs. It would offer vouchers that individuals could use to shop in the new insurance exchanges we are creating. Those who prefer their current plan to what is offered in the exchange could return the voucher and keep their existing coverage.

If we pass these amendments, we can credibly tell the American people that our long efforts will have addressed rising health insurance premium costs for everyone, and that is at the heart of this effort we have undertaken.

In closing, I will say that Americans are not looking for a Democratic solution or a Republican solution to our health care challenge. They are looking for us to come together to pass a reform bill that works in practical terms in their daily lives. More choices, premium cost increases under control, eliminating preexisting conditions—those are the things that will help middle-class families in my State and others across the country.

I am proud that the Wyden-Collins-Bayh affordability package will represent one of the few bipartisan efforts in this body. As I was saying, I regret the fact that it is one of the few, but I am proud we have come together to work to address this important challenge. I hope my colleagues will agree that we have a responsibility to restrain premium costs for all American families by encouraging consumer choice and robust competition in the private marketplace. I hope we will pass these amendments because they accomplish exactly that.

Madam President, thank you for your patience. I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Madam President, I wish to begin my part of this colloquy with Senator BAYH and Senator COLLINS by thanking my colleague from Indiana. I also thank my colleague from Maine because both senators have said from the very beginning of this discussion that the bottom line for millions of working families, for single moms, for folks who are walking on an economic tightrope across the country, they are going to see this issue through the prism of what it means for them in terms of their premiums and their costs.

Over these many months, Senator BAYH and Senator COLLINS and I have been toiling to put together some bipartisan ideas. We have filed these ideas as a package of amendments, submitted them to the majority leader, Senator REID, and the chairman of the Finance Committee, Senator BAUCUS, and we just wanted to take a few minutes today to talk in particular about why it is so essential that there be a bipartisan effort put together for additional steps to contain costs.

Senator BAYH is absolutely right in describing the Congressional Budget Office analysis. Certainly, many people were fearful the CBO report would come out and say that on day one after enactment premiums would rise into the stratosphere as a result of the legislation. Fortunately, that was not the case in the report for most people.

We also believe there is a whole lot more that can be done. So we have said, Democrats and Republicans are going to try to prosecute that case. What it comes down to is ensuring that, in the text of this legislation, there is more choice and more competition.

The reality is, ever since the 1940s, the days of the wage and price control decisions that have done so much to shape today's health care system, most Americans have not had real choice in the health care marketplace and have not been able to enjoy the fruits of a competitive system. Most Americans have little or no choice. Most Americans don't get a chance to benefit when they shop wisely.

As Senator BAYH noted—and as Senator COLLINS and I have noted over the last few days—that is something we ought to change. It is certainly not a partisan idea. Senator REID and Senator BAUCUS, to their credit, have agreed with me that there ought to be more choice for those folks who have what, in effect, are hardship exemptions under this legislation. There are people, for example, who spend more than 8 percent of their income on health who aren't eligible for subsidies, who have these hardship exemptions; and Senator REID, Senator BAUCUS, and I have agreed they ought to be able to take any help they are getting from their employer in the form of a voucher and go into the marketplace. These people should be able to put into their pockets any savings that come about because they have shopped wisely.

But as Senator BAYH has noted, we have an opportunity to go further. If an employer in the exchange decides, on a voluntary basis, that their workers should have a choice, under the proposal advanced by the Senator from Indiana, the Senator from Maine, and myself, they would be able to do it.

It is the voluntary nature of our idea that Senator BAYH has outlined, an approach that gives more options to both employers and employees, that caused our proposal to win an endorsement from the National Federation of Independent Business.

I ask unanimous consent at this time to have printed in the RECORD that 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 10, 2009.

Hon. RON WYDEN,
U.S. Senate, Dirksen Senate Office Building, Washington, DC.

Hon. SUSAN COLLINS,
U.S. Senate, Dirksen Senate Office Building, Washington, DC.

DEAR SENATORS WYDEN AND COLLINS: On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business association, we are writing in support of the Wyden-Collins amendment (Optional Free Choice Voucher—amendment #3117), which provides vouchers as a new voluntary option for employers and employees to purchase health insurance.

For small business, the goal of healthcare reform is to lower costs, increase choices and provide real competition for private insurance. The Wyden-Collins amendment achieves what we know are clear bipartisan goals in healthcare reform—expanding access to coverage, increasing consumer choice and improving portability.

Free choice vouchers recognize that the employer-employee relationship in America has changed considerably since employer-sponsored insurance began in the 1940s. They give employees tax- advantaged resources to tailor healthcare choices and purchases to their own preferences and needs. Because the employees will be able to choose from more policies, they will be more invested in their healthcare decisions. They will be better

consumers because they will be more aware of costs, and this will help ''bend the cost curve.''

In today's diverse and highly mobile workforce, people change jobs every few years. Improving portability will reduce the ''job lock'' that currently stifles entrepreneurship. Since free choice vouchers would help make health insurance portable, employees will not be locked into jobs when better opportunities come along.

This amendment addresses the shortcomings of the existing employer-based system for small businesses. In the current system, small employers often have few options beyond ''take it or leave it.'' This new and voluntary option will encourage employers to provide insurance coverage for employees. It is the exact opposite of employer mandates that harm struggling businesses, discourage startups and kill jobs.

While some may claim this amendment weakens employer-sponsored health insurance, NFIB disagrees. The current system works better for larger firms who can operate more efficiently and effectively, and this inequity must be addressed. Simply put, what works for Wall Street does not work for Main Street. The Wyden-Collins amendment works to address this by making coverage more affordable for many of the nation's job creators.

NFIB appreciates your commitment to healthcare reform and your continuous efforts to find solutions that work for small business.

Sincerely,

SUSAN ECKERLY,
Senior Vice President,
Public Policy.

Mr. WYDEN. Madam President, I will make one last comment and then we will be happy to have our colleague from Maine join us in this bipartisan colloquy.

As we go forward with this legislation, I hope we will do more to look at the exchanges, which are the new marketplace for American health care. We haven't had that kind of approach since decades ago when we had a discussion about a system that, for all practical purposes, tethered people to one choice that was a judgment by an employer and insurance company. I wish to make sure, in the days ahead, that as many people as possible can keep exactly what they have today. That is something the President feels strongly about. That is something every Member of the Senate feels strongly about. I also want employers and employees to be able to say they are going to have a broader range of choices than they do now.

I think that can be done in a way that does not destabilize employer-based coverage. In fact, I believe it will strengthen employer-based coverage. I think that is one of the reasons the National Federation of Independent Business has endorsed our proposal.

We have a lot of work to do. I think there is a lot of good faith among Senators on both sides to get this done. I have always felt that on issues such as this, when you are talking about one-sixth of the American economy, you ought to try to find as much common ground as you possibly can. The three of us have come together behind a new set of amendments that does find some bipartisan common ground, around principles the President has embraced—choice and competition.

At this point, I yield whatever time she desires to our friend from Maine, who is a wonderful partner in this, along with Senator BAYH. Americans are looking for commonsense ideas above all else. That is what we have sought to do in this proposal.

I yield to my friend from Maine.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. COLLINS. Madam President, first, let me thank my two colleagues for their hard work on these amendments. My colleague from Oregon, Senator WYDEN, has been working so hard on health care issues for such a long time. My colleague from Indiana, Senator BAYH, and I have worked together on other issues, and I am proud of the fact that the three of us have been able to come together, in a bipartisan way, to present to our colleagues three important amendments.

It is, as Senator BAYH has noted, so unfortunate that the debate on this bill has been so divisive and partisan. Senator WYDEN approached me about trying to find some common ground on issues that would unite us.

I should make clear the adoption of these amendments—important though they are and great steps forward though they are—do not solve all the problems I have with the legislation before us. But they do improve the underlying bill in important ways because they help to advance the goal of more affordable insurance choices for consumers. Providing more choices and more competition and greater affordability, after all, should be major goals of health care reform.

The bill before us falls short in meeting those objectives.

Let me discuss our amendments. In summary, our amendments would allow individuals, who are not receiving subsidies, to purchase lower cost plans if that coverage is more affordable for them and more appropriate for them.

We are also proposing health insurance vouchers that would provide more options for employers and employees alike. We are proposing incentives to insurers to keep their rates lower than they otherwise might be.

Let me further explain our three amendments. First, we would open the catastrophic plan—the so-called young invincibles plan—in the individual market to anyone, regardless of age, who is not eligible for a subsidy under the bill.

It is incredible to me that we are going to so constrain the insurance choices for an individual who is receiving no taxpayer subsidy at all. That does not make sense. We want to ensure not only that people can keep the insurance they have, if they like it, but also that they have more options available to them. Why should we say that an individual who is not receiving any help—no subsidy at all—can only purchase one of the four types of plans that are authorized by this bill?

Some would say, well, if you do that, you are going to have a problem where a person will perhaps have a health savings account or a supplemental catastrophic insurance plan and wait until they are ill to trade up to a far better plan. But there is a way to stop that from happening. We have drafted our amendment so that if an individual wished to upgrade his or her coverage, he or she would have to wait until the next plan year and then could only upgrade to what is known as the bronze plan—the next higher level of coverage. That would help greatly to avoid the problem of adverse selection and having a situation where an individual simply waits until he or she becomes ill before upgrading coverage.

We also wish to make sure consumers know exactly what they are buying and what kind of coverage they are getting. That is why we would require health plans to disclose fully the terms of the coverage to ensure that consumers fully understand the limitation.

Finally, this amendment makes clear that States have the ability to impose additional requirements or conditions for the catastrophic plans offered under this bill.

The bottom line is, health care reform should be about expanding access to affordable choices. The bill that is on the floor now would cause many Americans in the individual market to pay more for health care coverage than they do today. That isn't right. If their health care coverage is working well for them, if they are higher income and can bear the risk, if they have a health savings plan, if they are not getting a taxpayer subsidy, why should we dictate, to this degree, the level of coverage they can buy?

I believe this amendment is simple common sense. Let me explain what it would mean in my home State of Maine because I think it shows that one size does not fit all. In Maine, 87.5 percent of those purchasing coverage in the individual market have a policy with an actuarial value of less than 60 percent. The most popular individual market policy sold in Maine costs a 40-year-old about $185 a month. These individuals often pair this catastrophic coverage with a health savings account.

Under the bill we are debating, unless they are grandfathered and don't have any change—for example, they have not gotten married or divorced—then that 40-year-old would have to pay at least $420 a month—more than twice as much—for a policy that would meet the new minimum standard. Otherwise they would have to pay a $750 penalty.

There is an exception in the bill, but it is only for people who are under the age of 30. What we are saying is, let's broaden that, so that if you don't receive help from the government, if you don't receive a taxpayer subsidy, you, too, can buy that kind of catastrophic coverage plan.

A second amendment the three of us are offering would provide more choices to small businesses and to their employees. Giving employers and employees more choices should be among the chief goals of health care reform.

Our amendment would allow employers who choose to do so to offer vouchers to employees so they can purchase insurance on the exchange. This would allow them, for example, to use the employer voucher, plus tap into the subsidy available because of their income level, and put some of their own funds into purchasing the kind of coverage they want. As Senator WYDEN has explained, this program is completely optional. Employers could offer these vouchers or decide to continue with their employer plan.

Let me tell you one reason I think this strengthens the bill. We need more people buying insurance through the exchanges, because if more people are using the exchanges, it broadens the risk pool, and the rates will be better for everyone. In insurance, having more people over which to spread the risk drives costs and premiums down.

So it is not surprising to me that our Nation's largest small business group, the NFIB, has endorsed our amendment. Let me read one paragraph from the NFIB letter because it really sums it up. The NFIB says:

> This amendment addresses the shortcomings of the existing employer-based system for small businesses. In the current system, small employers often have few options beyond ''take it or leave it.'' This new and voluntary option will encourage employers to provide insurance coverage for employees. It is the exact opposite of employer mandates that harm struggling businesses, discourage startups, and kill jobs.

I think the NFIB has said it well. This will give more choices both to employers and to employees.

Finally, let me say a few words about our proposal to modify the formula for the allocation of the $6.7 billion annual tax on health insurance providers.

There are a lot of problems with that particular tax, not the least of which is the gap between when the tax is imposed and when the subsidies are finally available 4 years later. Another problem is that the tax applies to nonprofit insurers as well as for-profit insurers. I am working with Senator CARL LEVIN to try to address that problem.

Here is what we are saying. The way the tax is designed in the bill, there is little to keep insurers from jacking up premiums, which is exactly the opposite of what we want them to do. They are going to just pass this tax on. So what we propose is to give insurers an incentive to keep premiums as low as possible. Under our amendment, if you are an insurer that is holding down the cost of your premiums, you don't pay as large a share of the tax. That makes sense. That helps us be more fair to the efficient insurer that is working hard to keep premiums down.

Again, I am very pleased to join with my two colleagues in presenting to the Senate three amendments that will provide more choices, greater affordability, and more options. These should be the goals of health care reform, and these amendments help to advance those goals.

Mr. WYDEN. Madam President, how much time do we have?

The PRESIDING OFFICER. There is 3 minutes 50 seconds remaining.

Mr. WYDEN. Madam President, I thank my colleague from Maine for her great statement. She summed it up so well.

To close, I will turn to Senator BAYH, and if we have time, I will add a thought or two.

Mr. BAYH. Madam President, I will be brief. I compliment Senator COLLINS on an excellent presentation. She summarized it very succinctly and in a way that was compelling.

I hope our colleagues will take note that among the three of us, we have the east coast represented, the west coast represented, and the Midwest represented. So we span the country and this body. I hope that will cause our colleagues to take some note.

The Senator from Maine focused on the letter from the NFIB. This helps small businesses at a time when they are struggling to create jobs. I hope our colleagues will take note of this letter.

The Senator from Maine also pointed out, why should we control the health care choices of individuals who are receiving no subsidies. That ought to be up to them. We accomplish all of those things.

It is a pleasure doing business with Senator COLLINS. This is a practical approach to solving these problems. I hope our colleagues will take notice.

The last thing I will say is, I repeatedly have people come up to me and say: Boy, RON WYDEN has some great ideas. We need more of these ideas in this bill. And this is accomplishing that. Senator WYDEN has been a true leader for many years in this area. I am glad choice and competition is being introduced, and it is because of his good work.

Mr. WYDEN. Madam President, to close, briefly, I thank my colleagues. I don't want to make this a bouquet-tossing contest, but to have Senator BAYH and Senator COLLINS—they are as good of partners as it can possibly get.

At the end of the day, Americans are going to watch this bill, they are going to watch it next year during the open enrollment season when millions are signing up for their coverage, and they are going to be looking to see if we did everything possible to hold down their premiums. Holding down their premiums—there is a variety of ways to go about it, but there is no better tool than to bring the principles of the marketplace, the principles that are used in every other part of American life—choice and competition—for the challenge ahead.

With the help of Senator COLLINS and Senator BAYH, we are going to prosecute that case. We are going to do it in a bipartisan way.

I thank my colleagues. I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Madam President, I ask unanimous consent that Republican Senators be permitted to engage in a colloquy during our time.

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

Mr. ALEXANDER. Madam President, my grandfather was a Santa Fe railway engineer. He lived in Newton, KS. So far as I can tell, he was one of the most important men in the world. I was 5, 6, 7 years old when I would go out there. He drove one of these great big steam locomotives. If there were as many yellow flags and red flags along the track when he was driving that Santa Fe locomotive as there are with the health care locomotive that is going through the Senate today, I think my grandfather would have been guilty of gross negligence if he did not slow it down and see what those red flags and yellow flags meant.

There is a lot of talk about making history with this bill, but there are a lot of different ways to make history. One of the things I hope we will be very careful to do in the Senate is not to make a historic mistake with this health care legislation.

Now we have even one more red flag to consider. It came out last night from Chief Actuary Richard Foster of the Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services is not a Republican organization nor a Democratic organization. It is in the Obama administration. But it is the agency in charge of the Federal Government's spending for health care, which, according to Mr. Samuelson, who wrote a column in Newsweek recently, was 10 percent in the year 1980 and 25 percent today of our government's total expenditures.

If we go back to the reason we started all this debate on health care, let's remember that the reason we started the debate was first to see if we can bring down the costs of health care because the red flags and the yellow flags are everywhere for small businesses, for individuals, for our government. We cannot continue to afford the increasing cost of health care in America. So our first goal here is to bring down the costs.

Yet, Mr. Foster, the Chief Actuary of the Centers for Medicare and Medicaid Services, in a lengthy report delivered last night on the health care bill—most of which we have seen but some of which we do not know about yet; it is still being written in the back room—says that it will increase costs. Instead of reducing costs, it will increase costs. It points out the obvious, which is that the taxes in the bill will raise the premiums for the 180 million of us pay who have employer-based insurance, and for those who have individual insurance. It talks about the millions of Americans who will be losing their employer insurance by the

combination of provisions in this bill, many of whom will end up in Medicaid, where 50 percent of doctors will not see a new patient. But maybe the most important finding is the most obvious finding, the one which we have been suggesting to our colleagues day-in and day-out. It is one we ought to pay attention to and one which almost every American can easily understand. And it is this—it has to do with Medicare, the government program on which 40 million seniors depend. This bill would cut $1 trillion—let's start this way. Medicare, the program we depend on, its trustees say it is going broke in 5 years. It is already spending more than it brings in, and it will be insolvent between 2015 and 2017. Those are the Medicare trustees telling us this.

What does this bill do to that?

Mr. MCCAIN. Will the Senator yield for a question?

Mr. ALEXANDER. If I may finish my point.

What does this bill do? It would cut $1 trillion from Medicare. I ask the Senator from Arizona, if the program is going broke and you cut $1 trillion out—and then it has been suggested over the last few days that we add several million more people into Medicare—what do you suppose the result would be?

Mr. MCCAIN. The answer is, obviously, that I don't know.

I would like to say to the Senator from Tennessee—and Dr. BARRASSO is here as well—a lot of Americans have heard of the Congressional Budget Office. I am not sure many have heard of the Centers for Medicare and Medicaid Services, which is part of the Department of Health and Human Services. Are they not the people whose entire focus is not on the entire budget, as CBO's is, but just on Medicare and Medicaid, so that they can make determinations as to the future and the impact of various pieces of legislation on specifically Medicare and Medicaid? Is that a correct assessment?

Mr. ALEXANDER. The Senator from Arizona is exactly right. I believe I have my figures right. I think Mr. Samuelson said in his column the other day that in 1980 the Federal Government was spending 10 percent of all our dollars on health care and today it is 25 percent. And this is the agency in charge of most of that massive Federal expenditure every year.

Mr. MCCAIN. I thank my friend. Because the findings as of December 10, 2009, which is entitled "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act of 2009,' as Proposed by the Senate Majority Leader on November 18, 2009," have some incredibly, almost shocking results, I say to my friend from Tennessee.

We know the bill before us does not bring costs under control. But as I understand this—and it is pretty, may I say, Talmudic in some ways to understand some of the language that is in this report, but is it not true that the Reid bill, according to this report—this is not the Republican policy committee but the Centers for Medicare and Medicaid Services—doesn't it say:

> The Reid bill creates a new long-term insurance program—

Called the CLASS Act—

> that the CMS actuaries found faces "a very serious risk" of becoming unsustainable as a result of adverse selection by participants. The actuary found that such programs face a significant risk of failure and expects that the program will result in "net Federal cost in the long term."

I would like to mention two other provisions to my friend from Tennessee and Dr. BARRASSO, who is very familiar not only with this center but with Medicare and Medicaid services.

> The Reid bill funds $930 billion in new Federal spending by relying on Medicare payment cuts which are unlikely to be sustainable on a permanent basis. As a result—

According to CMS—

> providers could "find it difficult to remain profitable and, absent legislative intervention, might end their participation in the Medicare program."
>
> The Reid bill is especially likely to result in providers being unwilling to treat Medicare and Medicaid patients, meaning that a significant portion of the increased demand for Medicaid services would be difficult to meet.

They go on to say:

> The CMS actuary noted that the Medicare cuts in the bill could jeopardize Medicare beneficiaries' access to care. He also found that roughly 20 percent of all Part A providers (hospitals, nursing homes, etc.) would become unprofitable within the next 10 years as a result of these cuts.

Finally, he goes on to say:

> The CMS actuary found that further reductions in Medicare growth rates through the actions of the Independent Medicare Advisory Board—

Which is one of the most controversial parts of this legislation—

> which advocates have pointed to as a central lynchpin in reducing health care spending, "may be difficult to achieve in practice."

This is a remarkable study, I say to my friend from Tennessee.

Mr. ALEXANDER. I thank the Senator from Arizona for being so specific about this and making it clear that this is not a Republican Senator talking, this is a Republican Senator reading the report of the Federal Government's Chief Actuary for the Medicare and Medicaid Program. Senator BARRASSO, a physician for 25 years in Wyoming, brought to our attention some of these things earlier this week when he pointed out what this also says.

Isn't the point that if we keep cutting Medicare, there are not going to be any hospitals and any doctors around to take care of patients who need care?

Mr. MCCAIN. May I also ask, in addition to that question, has Dr. BARRASSO ever heard of the CMS being biased or slanted in one way or another? Isn't it one of the most respectable and admired objective observers of the health care situation as far as Medicare and Medicaid are concerned?

Mr. BARRASSO. My answer to that is they are objective. That is why we did not get this report—I have the same copy my colleague from Arizona has. This just came out, and the reason is because they wanted to take the time to study the bill which they got in the middle of November. So they needed the time to actually go through point by point what the implications were.

The Senator talked about the one segment where they talk about they "face a significant risk of failure." They actually go on to say: "This will eventually trigger an insurance death spiral." This is for people who depend upon Medicare for their health care.

There is an Associated Press story out today that says this provides a sober warning—a sober warning—today to Members of the Senate. This is a time when the Senate raised the debt limit in this country by over $1 trillion. As the old saying goes—I say to my friend who served in the Navy—they are spending money like drunken sailors, and yet they want to keep the bar open longer. They want to increase the debt at a time when our Nation cannot afford it, when we have 10 percent unemployment.

The folks who know Medicare the best and can look at this objectively and share with the American people what their beliefs are as to what the impact is going to be say that is going to be devastating for patients who rely on Medicare for their health care—our seniors—and devastating for small community hospitals. I see the former Governor, now Senator of Nebraska, is here, and he knows, as I do from Wyoming, the impact on our small community hospitals.

But as the Senator from Tennessee said, this is all being done in a back room. We are not privy to the newest changes, which I think are actually going to make matters worse. The New York Times today says Democrats' new ideas would be even more expensive. Questions exist about the affordability. What we are dealing with is a situation that is unsustainable, and that is why the newest poll out today by CNN—certainly not biased one way or the other—finds that 61 percent of Americans oppose this bill. It is the highest level of opposition to date because more and more people are seeing and learning the truth about what is being proposed in the bill before the Senate.

Mr. MCCAIN. This is the information on the bill as it is; correct—the original bill? This is without the expansion of Medicare taken into this study, which already, as the Senator quoted from the New York Times and other health care experts, is going to increase costs even more. As you expand Medicare, among other things, you run the risk of adverse selection, which means the people who are the sickest immediately enroll, which then increases the cost, and then who would be paying the increased Medicare payments? The young and the healthy. I

ask my friend from Wyoming, should we do that to the next generations of Americans?

Mr. BARRASSO. Well, we should not. We need to be fair. We need to deal with this in a realistic way. But the bill in front of us now is going to raise taxes $500 billion, it is going to cut Medicare by almost $500 billion for our seniors who depend upon it, and for people who have insurance they like, it is going to increase their premiums. They are going to end up paying more than if no bill was passed at all.

That is why, across the board, more people would rather have this Senate do nothing than to pass this bill we are looking at today. They understand the impact on this Nation and our future is devastating. This will cause us to lose jobs, with the taxes; it will cause us to lose care in small communities; and for our seniors who depend upon Medicare, they are going to throw more people into Medicaid, another program where half the folks now can't find a doctor who will see them.

All in all, there is nothing I see about this bill or any of the new changes and certainly nothing in this report that says to the American people: Hey, you might want to think about this. The American people have thought about it. This report tells the American people this is not what they want for health care in this Nation.

Mr. ALEXANDER. Madam President, I ask unanimous consent to have printed in the RECORD the summary of the report of the Centers for Medicare & Medicaid Services.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY,

Baltimore, MD, December 10, 2009.

From: Richard S. Foster, Chief Actuary.

Subject: Estimated Financial Effects of the ''Patient Protection and Affordable Care Act of 2009,'' as Proposed by the Senate Majority Leader on November 18, 2009.

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the Patient Protection and Affordable Care Act. We offer this analysis in the hope that it will be of interest and value to policy makers as they develop and debate national health care reforms. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through fiscal year 2019 of selected provisions of the proposed ''Patient Protection and Affordable Care Act of 2009'' (PPACA). The estimates are based on the bill as released by Senate Majority Leader Harry Reid on November 18 as an amendment in the nature of a substitute for H.R. 3590. Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Except where noted, we have not estimated the impact of the various tax and fee proposals or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our estimates of national health reform proposals is available in the appendix to our October 21 memorandum on H.R. 3200.

SUMMARY

The table shown on page 2 presents financial impacts of the selected PPACA provisions on the Federal Budget in fiscal years 2010–2019. We have grouped the provisions of the bill into six major categories:

(i) Coverage proposals, which include both the mandated coverage for health insurance and the expansion of Medicaid eligibility to those with incomes at or under 133 percent of the Federal poverty level (FPL);

(ii) Medicare provisions;

(iii) Medicaid and Children's Health Insurance Program (CHIP) provisions other than the coverage expansion;

(iv) Proposals aimed in part at changing the trend in health spending growth;

(v) The Community Living Assistance Services and Supports (CLASS) proposal; and

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the bill as released. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the insurance coverage provisions and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year following enactment. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10–year cost for the proposed legislation.

ESTIMATED FEDERAL COSTS (+) OR SAVINGS (−) UNDER SELECTED PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2009

[In billions]

Provisions	Fiscal year										Total, 2010–19
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total [1]	$16.1	−$1.6	−$18.6	−$35.2	$22.4	$78.1	$83.0	$76.2	$74.5	$71.0	$365.8
Coverage [2]					93.8	141.1	158.3	165.8	178.6	192.3	929.9
Medicare	11.5	1.3	−13.4	−24.3	−60.5	−52.0	−66.0	−80.9	−95.8	−113.3	−493.4
Medicaid/CHIP	−0.4	−0.1	−0.7	−5.3	−4.9	−4.9	−4.8	−4.9	−4.8	−4.8	−35.6
Cost trends					−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program		−2.8	−4.5	−5.6	−5.9	−6.0	−4.3	−3.4	−2.8	−2.4	−37.8
Immediate reforms	5.0										5.0

[1] Excludes Title IX revenue provisions except for 9015, certain provisions with limited impacts, and Federal administrative costs.

[2] Includes expansion of Medicaid eligibility.

[3] I Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates, which are reflected in the Medicare line.

As indicated in the table above, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes) are estimated to cost $930 billion through fiscal year 2019. The net savings from the Medicare, Medicaid, growth-trend, and CLASS proposals are estimated to total about $564 billion, leaving a net cost for this period of $366 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and other revenue provisions. (The additional Hospital Insurance payroll tax income under section 9015 of the PPACA is included in the estimated Medicare savings shown here.) The Congressional Budget Office and Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The chart shown on the following page summarizes the estimated impacts of the PPACA on insurance coverage. The mandated coverage provisions, which include new responsibilities for both individuals and employers, and the creation of the Health Benefit Exchanges (hereafter referred to as the ''Exchanges''), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchanges.

By calendar year 2019, the mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 57 million, as projected under current law, to an estimated 24 million under the PPACA. The additional 33 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 18 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 133 percent of the FPL. (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 20 million persons (most of whom are currently uninsured) would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies, and an estimated 20 percent choosing to participate in the public insurance plan option. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease overall by about 5 million, reflecting both gains and losses in such coverage under the PPACA.

As described in more detail in a later section of this memorandum, we estimate that total national health expenditures under this bill would increase by an estimated total of $234 billion (0.7 percent) during calendar years 2010–2019, principally reflecting the net

impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid, and (iii) lower payments and payment updates for Medicare services, together with net Medicaid savings from provisions other than the coverage expansion. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansions.

The actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation. Consequently, the estimates presented here are subject to a substantially greater degree of uncertainty than is usually the case with more routine health care proposals.

The balance of this memorandum discusses these financial and coverage estimates—and their limitations—in greater detail.

EFFECTS OF COVERAGE PROPOSALS ON FEDERAL EXPENDITURES AND HEALTH INSURANCE COVERAGE

Federal expenditure impacts

The estimated Federal costs of the coverage provisions in the PPACA are provided in table 1, attached, for fiscal years 2010 through 2019. We estimate that Federal expenditures would increase by a net total of $366 billion during this period—a combination of $930 billion in net costs associated with coverage provisions, $493 billion in net savings for the Medicare provisions, a net savings of $36 billion for the Medicaid/CHIP provisions (excluding the expansion of eligibility), $2 billion in savings from proposals intended to help reduce the rate of growth in health spending, $38 billion in net savings from the CLASS proposal, and $5 billion in costs for the immediate insurance reforms. These latter four impact categories are discussed in subsequent sections of this memorandum.

Of the estimated $930 billion net increase in Federal expenditures related to the coverage provisions of the PPACA, about two-fifths ($364 billion) can be attributed to expanding Medicaid coverage for all adults who make less than 133 percent of the FPL and all uninsured newborns. This cost reflects the fact that newly eligible persons would be covered with a 100-percent Federal Medical Assistance Percentage (FMAP) for the first 3 years and approximately 90 percent thereafter; that is, the Federal government would bear a significantly greater proportion of the cost of the newly eligible enrollees than is the case for current Medicaid beneficiaries.

Mr. ALEXANDER. I ask the Senator from Georgia, while this is a complex document, in many ways, isn't it a matter of common sense that if you take a program that is going broke and you take $1 trillion out of it and you add millions of people to it, isn't the end result going to be there is not going to be anyone left to take care of the patients who need help? Isn't that the logical result, just as this report says?

Mr. CHAMBLISS. Not only does that report say that, but as you say, common sense ought to tell you that. Unfortunately, it is pretty obvious the folks on the other side of the aisle who are promoting this bill don't get that message.

Let me quote the chairman of the Finance Committee, who today issued this statement relative to the CMS report the Senator has in his hand. He said:

> The report shows that health reform will ensure both the Federal Government and the American people spend less on health care than if this bill does not pass.

That statement is directly contrary to the statement in the CMS report that Senator ALEXANDER just referenced, which says:

> . . . we estimate that total national health expenditures under this bill would increase by an estimated total of $234 billion (0.7 percent) during calendar years 2010–2019.

Not only that, but the report says that national health expenditures would increase as a percentage of GDP from $1 of every $7, which is about 16 percent, to $1 out of every $5, which is 20 percent.

What the report concludes is not only are our health care costs going to go up, but as the Senator from Arizona said, 20 percent of all Part A providers—nursing homes, hospitals, home health—would become unprofitable within the next 10 years as a result of the provision in this bill relating to the Medicare cuts the Senator from Tennessee talked about.

The American people do get it. That is why these poll numbers the Senator from Wyoming just stated coming out of CNN and why the FOX poll I saw this morning said 57 percent of the people in America are opposed to this bill. The American people are getting it but, for some reason, our friends on the other side of the aisle are not.

Mr. ALEXANDER. I see the Senator from Nebraska is here, and we had a conversation earlier about the attitude of people in Nebraska. It is very helpful to have independent evaluators who tell us that if you cut $1 trillion out of a program that is going bankrupt and then add more people to it, doctors and hospitals are going to go broke. We have heard that before from the Mayo Clinic, and I think Senator JOHANNS has been hearing that in the State of Nebraska.

Mr. JOHANNS. I have heard it all over the State. Today, let me say, the fog cleared. The fog cleared and the Sun is shining brightly on this mammoth experiment with 16 percent of the economy. This actuary says, very clearly—and he has no ax to grind with anyone—that costs are going to go up under this bill; that care is going to be jeopardized under this bill; that the very linchpin, the essence of what this bill was supposed to be all about, can't happen.

If I might, I wish to refer to something which I will ask to be a part of the RECORD to gain some perspective.

I wish to applaud my colleagues on this side, and here is why. We wrote to the majority leader back in the first part of November and we said CBO had not been able to tell us what the ultimate impact would be on health care costs and we felt strongly we needed a second opinion. So we asked that this bill be submitted to scrutiny by CMS, and that is what we are getting today. Twenty-four of us signed onto that.

Madam President, I ask unanimous consent to have printed in the RECORD the letter to the majority leader, dated November 12, 2009.

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

U.S. SENATE,
Washington, DC, November 12, 2009.

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

DEAR MAJORITY LEADER REID: This health care bill will be the most significant piece of legislation that Congress considers this year because it would undoubtedly affect every American. Therefore, it is vitally important that we do not make decisions without a complete and thorough analysis of the bill.

One of the most important issues facing us as we review this legislation is its effect on overall health care spending. The President has repeatedly stated that he believes health reform should control health care costs. Achieving that objective, as you know, means more than simply employing draconian cuts in Medicare spending and creating numerous new taxes to minimize the effect of creating a vast new health care entitlement on the federal deficit. Bending the cost curve means curbing the rate of all health spending.

Unfortunately, the Congressional Budget Office has been unable to produce an estimate of the effect of the bills before us on overall medical spending though we note that the CMS Actuary has provided such an assessment of an earlier version of the House health reform bill (HR 3200). Such an analysis would be invaluable to the Senate as we consider this important legislation.

Therefore, we request that you submit the legislation to the Office of the Actuary at CMS for analysis and make the findings public before you bring the bill to the Senate floor for consideration. We agree with President Obama that health care legislation must "bend the cost curve so that we're not seeing huge health-care inflation over the long term." Therefore, we would specifically like the Office of the Actuary at CMS to determine if this legislation will bring down health care expenditures over the long term.

We look forward to your response and the assurance that this secondary analysis will be completed in order to provide us and the American people with the information necessary to make a well-informed vote.

Sincerely,

Mike Johanns; Sam Brownback; Pat Roberts; Robert F. Bennett; Tom Coburn; Richard Burr; Christopher S. Bond; Roger F. Wicker; John Barrasso; Michael B. Enzi; Jim Bunning; Mike Crapo; Orrin G. Hatch; Lamar Alexander; Susan M. Collins; John Thune; George S. LeMieux; Jim DeMint; Mitch McConnell; George V. Voinovich; John Cornyn; James E. Risch; Kay Bailey Hutchison; Lindsey Graham; Thad Cochran.

Mr. JOHANNS. Today, we finally have come to grips with the fact that all the promises made are not being fulfilled by this bill; that the $2.5 trillion that will be spent will accomplish nothing; that health care costs would not go down—they will, in fact, go up; and that people will lose their private insurance.

I tell you the most heartbreaking thing for me, and any other Senator who has rural hospitals, which is just about every Senator, is that 20 percent, as the Senator from Georgia points out, will be underwater. That means nursing homes that provide care for real people, and that means hospitals that provide services for real people. I tell you, in a State such as Nebraska, when hospital care disappears in a small town, that may mean hospital care disappears for hundreds of miles.

Mr. ALEXANDER. If I could ask the Senator from Nebraska this question. Did a rural hospital in Nebraska or Wyoming or some State not—did I notice in a letter from the Mayo Clinic this week, they said cuts such as this or an expansion of Medicare under these circumstances would cause them to—well, to drop Medicare, period; they lost $840 million this year, and they are beginning to say to some citizens from Nebraska, Montana, other areas: We can't take you if you are a Medicare patient or if you are a Medicaid patient.

Mr. JOHANNS. They are saying that, and that is what is happening because they are losing money. They are definitely losing money on Medicaid and they are losing money on Medicare.

So what the Reid bill does is it says: Mr. ALEXANDER, you sell whatever—cars. Let's use that as the analogy—and I know you are losing $100 on every car. But let's just give you twice as many to sell. Well, you are going to lose twice as much money. That is their solution to the health care crisis in this country.

But what this actuary points out, what the Mayo Clinic points out, and what so many analysts now have pointed out is that this bill is going to put hospitals under and it is going to put nursing homes under.

Here is another point that gets lost in this complex debate. That nursing home or that hospital may be the only major employer in that community. When you lose that, you not only lose your medical care, but you lose those jobs. I have said on the floor before that this bill is a job killer. It is a job killer. There is no way of getting around it. Those jobs will disappear in that small town, that rural area, and even in the big cities.

I hope our friends on the other side study this very carefully. This is a roundhouse blow to the Reid plan—to the Reid-Obama plan. This, in my judgment, proves, beyond a shadow of a doubt, that this is going to crush health care in our country.

Mr. ALEXANDER. I would ask the Senators from Wyoming and Georgia, who are here, to go back to the beginning. When we began this debate, the President, in his summit at the beginning of the year, very correctly—and I applauded him for that—all of us said we have to reduce health care costs—costs to us, costs to small businesses, and costs to our government. But doesn't this report of the chief actuary of the government say the Reid bill will actually increase health care costs?

Mr. BARRASSO. It does say that. The President has said he wanted to bend the cost curve down. This report says, if we do these things that are in the Reid bill, costs of care will actually go up faster than if we did nothing at all. That means for people who buy their own insurance, the cost of their premiums will go up faster than if this Senate passed nothing at all.

Mr. ALEXANDER. So if I am understanding it, we are going to cut $1 trillion, when fully implemented, out of Medicare; we are going to add $1 trillion in taxes, when fully implemented; we are going to run up the debt, we believe on this side; we are going to increase premiums and costs are still going up?

Mr. BARRASSO. For people all across the country, costs are still going to go up. The cost of doing business will go up. For families who buy their own insurance, the cost of their premiums will go up. For people who are on Medicare, they are going to see tremendous cuts into that program, and they depend on that for their health care. So costs are going up for people who pay for their own and for businesses that try to build jobs.

We know small business in this country is the engine that drives the economy, and according to the National Federation of Independent Businesses, 70 percent of all new jobs come from small businesses. They are going to be penalized to the point they are not going to be able to add those new jobs. The NFIB says we will lose across the country 1.6 million jobs over the next 4 years as the government keeps collecting the taxes but doesn't even give any of these health care services because those have all been delayed for 4 years.

Mr. ALEXANDER. We have about 6 minutes remaining in our time. I wonder if the Senator from Georgia, having heard the comments, has any additional recommendations on the chief actuary's report.

Mr. CHAMBLISS. I wish to ask a question or two of the Senator from Wyoming, who is a medical doctor and who, prior to coming to the Senate, was an active orthopedic surgeon.

I have had physicians come into my office by the droves and talk to me about Medicare before we ever got into this health care debate, and what I heard was in reference to the reimbursement rate under Medicare to physicians and to hospitals being so low.

In fact, the American Hospital Association has come out just in the last 24 hours and pointed out that hospitals across the Nation get a return of about 91 cents for every dollar of care provided. That is not 91 cents of the amount of charges from the hospital to Medicare, it is 91 cents of the cost of the care provided. So the return is about 10 percent less to a hospital than the cost that the hospital has in it.

My understanding is that at least 10 percent less than the cost provided for a physician is reimbursed to the physician under Medicare. As a result of that, the younger physicians, particularly, who are coming out of med school with these huge debts they have incurred as a result of the long years they are required to be in school, simply cannot afford to take Medicare patients and they are not taking Medicare patients. Is that in fact what is happening in the real world? And will that not get worse under this proposal?

Mr. BARRASSO. It is happening. It will get worse under the proposal that is ahead of us. That 90-percent figure is actually a high number. I know a number of physicians and hospitals, especially in rural communities, that get reimbursed less than that. The ambulance services do not even get reimbursed enough from Medicare—these are volunteer ambulance services—to fill the ambulance with the gas for taking somebody the long distances from where they may have fallen and hurt themselves, broken a hip, to get them all the way to the hospital. This is across the board bad for America.

We say we want patients to be able to get care. If you throw a whole bunch more people on to this boat that is already sinking, which is what the Democratic leader is now trying to do, it is going to make it that much harder for our hospitals to stay open, especially in these communities where there is only one hospital providing care—much more difficult. But with any young physician coming out with a lot of debt, trying to hire the nurse and pay the rent and the electricity and the liability insurance and all of that, these do not even cover the expenses. That means they have to charge more to the person who does have insurance, the cost shifting that occurs.

As a result, for people who have insurance, they are going to see their rates going up. For people who rely on Medicare, it is going to be harder to find a doctor. For those who are put onto Medicaid, with the aid for those who need additional help, which the Senate majority leader is trying to put more people into that area, it is going to be harder for them to find care.

Across the board, there is nothing good with this proposal. What we have seen today documented from the folks who are objective and look at the whole picture, they think it is actually as bad—they admit it is as bad as we have been saying it is. They say you guys have been right, what you are saying about the cost of care, the impact on health care. And their phraseology is such that I think they absolutely pinpoint all of the reasons that the American people, now by a number of 61 percent, oppose this bill we are taking a look at. That is why the Mayo Clinic has said, in the letter from their executive director of their Health Policy Center, ''Expanding this system to persons 55 to 64 years old will ultimately hurt patients by accelerating the financial ruin of hospitals and doctors across the country.'' That is what we are looking at.

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

The PRESIDING OFFICER. There remains 1½ minutes.

Mr. ALEXANDER. Madam President, if I could conclude our time, with the permission of the Senator from Georgia and Wyoming, instead of racing down this train track with yellow flags and red flags flying everywhere, people often ask us: What would you do? What we would do is what we think most Americans would do when faced with a big problem, not try to solve it all at once but to say, What is our goal? Our goal is reducing cost. What are the first four or five steps we can take to reduce costs? Can we an agree on those? We think we can. Let's start taking them. For example, small business health plans to allow small businesses to offer insurance to their employees at a lower rate. That legislation is prepared and before the Senate.

Reducing junk lawsuits against doctors. That reduces costs.

Allow competition across State lines for insurance policies. That reduces costs.

Going step by step to re-earn the trust of the American people to reduce health care costs is the way to go, instead of making what this new report from the Center for Medicare and Medicaid Services helps to show again would be a historic mistake.

I yield the floor.

Mr. ROBERTS. Will the Senator yield for an observation?

Mr. ALEXANDER. Certainly.

Mr. ROBERTS. I thank the Senator for yielding.

The PRESIDING OFFICER. The time of the Senator has expired. The Senator from Kansas.

Mr. ROBERTS. Madam President, I will be very brief. I thank the Senator from Tennessee, not only for his statement but for his constant efforts. Facts are stubborn things. Yet he has pointed out basically what this report now confirms. During the last few months we have seen some commentary that says ''scare tactics,'' of all things. I happen to have the privilege of being the chairman of the Rural Health Care Caucus. I was in the House of Representatives when I had the privilege of serving there and I am a cochairman with Senator TOM HARKIN of Iowa. There are about 30 of us who, from time to time, will correspond and meet and send messages back and forth to try to keep the rural health care delivery system viable.

We have been worried for some time in regard to what is going to happen to Medicare, what is going to happen in regard to cost, what is going to happen in regard to rationing. Every hospital director, every hospital board in rural America has worried about these things—more especially about CMS, which has been described here in detail. That is the Centers for Medicare and Medicaid Services.

I have to tell you, if you are a hospital administrator or if you are on the board of a local hospital in a rural area, and you hear the word CMS, it is probably not viewed in the best of considerations, that CMS is in charge of enforcing what H2S comes down with. So in terms of reimbursement, in terms of all things—competitive bidding—and I am talking about doctors, hospitals, nursing homes, home health care, hospice, all of this—when they hear the word CMS a cold chill goes down the back of their neck, more or less like expecting Lizzy Borden to come in the front door.

So I am especially glad that the actuary, Mr. Richard Foster, the Chief Actuary from CMS, has shined the light of truth into darkness. He has taken the original bill we have been talking about for some time, as my colleague has pointed out, and said basically this bill is going to increase costs and is going to result in rationing. It does not take into consideration the latest iteration that we hear from the press and media about including people 55 to 65 into Medicare. It is going to be interesting, if we have enough time—although I know that the distinguished majority leader has asked for a CBO score—but I would sure like to know what Mr. FOSTER would think of that idea. I think it would be far worse.

I encourage all of my colleagues who belong to the Rural Health Care Caucus to take a very hard look at this. This confirms what we have been saying for some time. These are not scare tactics, these are actual facts.

Let me say, too, I know when this debate first started some of the national organizations that represent doctors and hospitals, perhaps nursing homes—certainly not any home health care—well, I take that back. There was a letter written by the home health care folks at one time, but certainly not hospices—indicating that they were lukewarm, warm to the bill, or would perhaps support it. I think the message was pretty clear—come to the breakfast or you won't come to lunch. That was pretty bare knuckles but they hoped that at least by insuring those who have insurance, that would make their situation better.

Then, of course, came the latest iteration to this bill of putting in people 55 to 65, and the national association, in regard to our doctors and our hospitals, said: Whoa.

Let me point out in Kansas and in many States throughout the country there never was the support. They knew exactly what would happen if we passed this bill and CMS would come knocking on their door. I might add it wouldn't be CMS that would actually do that, it would be the Internal Revenue Service under this bill, and that was one consideration where I made about a 15-minute speech and obviously not too many people paid attention. But all patients, all doctors, all nurses, all clinical lab folks, anybody connected with the home health care industry or hospice or nursing homes or whatever, should have known it is going to be the IRS that is going to enforce this as well as CMS, which has been doing most of the enforcing.

In Kansas, the Kansas Medical Society said: No, no, we are not going to go along with this bill. I am talking about the bill we have been talking about for some time. The Kansas Hospital Association was adamant. They said no. Obviously that was because of advice they got from 128 hospitals in my State, saying: No, we cannot reconcile with this because of cost, because of the rationing. We are only being reimbursed at 70 percent or less, as we talk about it—and the doctors about 80 percent.

Many doctors do not serve Medicare now in Kansas. Let me rephrase that. Some doctors don't serve Medicare in Kansas. If this bill passes, a lot of doctors simply will not serve Medicare. You can have the best plan or the best card in the world, it is not going to make any difference if you can't see a doctor. It is not worth a dime.

Then I have to say the Kansas Nursing Home Association and Kansas Home Health Care folks and the Kansas Hospice folks all said: No, this is not where we want to go. This is self-defeating. This is not going to do what the sponsors of the bill and what everybody for health care reform hoped they would actually see happen.

I don't know what the word is, I am—not overwhelmed, I am extremely glad; I am somewhat surprised but I am extremely glad that CMS again shined the light of truth into darkness. I commend Mr. FOSTER, the chief actuary. I recommend this as required reading for everybody who was going to vote for this bill and certainly with the latest iteration, where we are adding anywhere from 10 to 20 to 30 million people to Medicare, which will make the situation much worse in regard to Medicare being actuarially sound and costs going up, premiums going up, and also rationing, the dreaded rationing. It is not a scare tactic but actually a fact.

I yield my time.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Madam President, I have been on the floor now for about an hour listening to my colleagues on the health care debate. Certainly I want to express the opinion from many people in the Northwest. We know that doing nothing about health care certainly will guarantee that premiums will go up. We know it happened in the last 10 years; they have gone up 100 percent. We know that doing nothing now means they will go up 8 to 10 percent a year. We also know there is about $700 billion in waste in the system.

This is about what we can do to reform the system so we can stop the rise, the increase we are seeing in our premiums. There are many things in this legislation, changing fee-for-service systems so we are driving down the quantity of health care that is delivered instead of making sure that it is quality; making sure we make reforms in long-term care; making sure we give

the power to States to negotiate and drive down the costs. I know my colleague Senator COLLINS was on the floor with some of my other colleagues, the Senators from Oregon and Indiana, to discuss their ideas about how we improve cost containment.

I hope my colleagues in the next days will join us in the discussion about how we continually improve the bill to drive down costs, because doing nothing will not get us to that point.

(The remarks of Ms. CANTWELL and Ms. COLLINS pertaining to introduction of S. 2827 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Ms. COLLINS. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. CRAPO. 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. CRAPO. Madam President, I ask unanimous consent to be able to enter into a colloquy with my Republican colleagues for up to 30 minutes, and that following those remarks, the Republican leader be recognized, and that following his remarks Senator DURBIN be recognized to speak.

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

Mr. CRAPO. Thank you, Madam President.

Madam President, I would like to speak on health care. The pending business before the Senate right now is actually the Omnibus appropriations bill, which the Senate moved to yesterday, after having started the debate on the health care legislation.

My motion is the pending business on the health care legislation, and so it is that motion I would like to talk about. Before I do so, I would like to again raise objection and concern to the fact that we have moved off the health care legislation debate to the Omnibus appropriations bill, both because I believe we should stay on the health care issue and work it through, but also because we moved to an Omnibus appropriations bill that we have not had an opportunity to review carefully and that raises the spending—I believe for these seven appropriations bills that have been compiled together, the spending is raised by an average of about 12 percent.

Once again, Congress is in a spending free fall, and whether it be the stimulus package or the appropriations for our ordinary operations of government or whether it be the bailouts or the tremendous other aspects of spending pressures and proposals, including the health care legislation we have, there seems to be no restraint in Washington with regard to spending the taxpayers' dollars.

But let's talk for a minute about the motion that was before the Senate before we moved off the health care legislation. It was a motion I raised to object to the tax increases on the middle class in America that are contained in the bill.

The motion I have is very simple. It focuses on the President's pledge. The President pledged that ''no family making less than $250,000 will see their taxes increase—not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.'' The President pledged: You will not see any of your taxes increase one single dime.

So the motion I brought was very simple. It was simply to commit the bill to the Finance Committee to have the Finance Committee go through the 2,074-page bill and remove from the bill the taxes that are in it that apply to the middle class in the United States, as defined by the President here: being those who, as a couple, are making less than $250,000 a year, or those, as an individual, who are making less than $200,000 a year.

What we have seen is that not only has there been delay on reaching that goal but a counterproposal to the amendment has been brought up by the chairman of the Finance Committee, Senator BAUCUS. His counteramendment says:

> It is the sense of the Senate that the Senate should reject any procedural maneuver that would raise taxes on middle class families, such as a motion to commit the pending legislation to the Committee on Finance, which is designed to kill legislation that provides tax cuts for American workers and families, including the affordability tax credit and the small business tax credit.

A number of us are here today to talk about the fact that this sense of the Senate is designed to provide cover for those who do not want to vote to protect American taxpayers. It is a meaningless sense of the Senate. We are going to go through the sense of the Senate phrase by phrase.

I would like to ask my colleague from the State of Wyoming if he would like to step in on the first phrase and comment. The first phrase says what the amendment is: ''It is the sense of the Senate . . .'' Would my friend from Wyoming like to comment on what that means?

Mr. BARRASSO. I would be happy to. OK, so we agree, it is the sense of the Senate. It is meaningless in terms of actually having the force of law. The Senator talked about the issues of the spending and the taxes, so we came up with a sense of the Senate.

This is why we are asking people all across the country to read the bill. The sense of the Senate essentially means nothing. It says we kind of agree on this, but there is no law applied.

Mr. CRAPO. Exactly. It is very critical to point out, a sense of the Senate has no binding impact. It is just sort of what we think.

Let's go to the next phrase in the amendment: ''that the Senate should reject any procedural maneuver that . . . '' in other words, the Senate should reject a procedural maneuver.

First of all, if the Senate is going to reject a procedural maneuver, that refers to what is happening on the Senate floor, procedural efforts. It does not refer to any substantive measure in the bill. The amendment we had pending—which this is going to be a counterpart to—specifically refers to the substance of the bill and says the substance of the bill should be changed to take out the taxes, the hundreds of billions of dollars of taxes.

I wonder, before we go to the next phrase, does my colleague from Wyoming care to comment?

Mr. BARRASSO. Well, I do care to comment. I care to comment that the important thing is to get the taxes out of the bill—not what a sense of the Senate is, not some procedural maneuver. It is the specifics of removing the taxes from the bill.

When the President says, ''My plan won't raise your taxes one penny,'' which was his quote, we need to be able to make sure the President is telling us the truth, that we need to remove these taxes from the bill.

The Joint Committee on Taxation looked at this bill—specifically looked at this bill—and it said that 38 percent of the people earning less than $200,000 a year will see a tax increase—a tax increase under the Reid bill.

So we want to make sure the President's words go with what is in the bill. So we need to actually remove the taxes—not just have a sense of the Senate.

Then, when we look at the chief of staff of the Joint Committee on Taxation, he was asked a question at the Finance Committee, and he said, when it all ''shakes out,'' we would expect people who are going to be paying taxes are going to have incomes ''less than'' the number the President said.

So I want to get to the point of the Crapo amendment, the amendment that actually says: Get these taxes out of the bill. This is a bill that is going to raise taxes by $500 billion, and those are taxes that are going to impact all Americans.

At a time when we have 10-percent unemployment, when the Senate is being asked to increase the debt level by another almost $2 trillion, the last thing we need to be spending our time on is a sense of the Senate. We need to actually get to those taxes that are going to affect the people, the hard-working people of America get those taxes out of the bill.

So as we are looking at that Baucus amendment; it is very nice, but it reminds me of the Bennet amendment we had here last week, and I think everybody voted for it. The New York Times, in their editorial, said it was a meaningless amendment. I want an amendment with some teeth in it that I can vote for, and I am ready to vote right now.

Mr. CRAPO. I thank my colleague from Wyoming.

The next phrase in the amendment—referring to a procedural motion—says that ''would raise taxes on middle class families.''

There is nobody bringing a motion to raise taxes. My amendment says it is referring the bill to the Finance Committee to take out the taxes on those who earn less than $200,000 or $250,000.

I note that my colleague from Kansas has arrived.

Would the Senator care to jump in at this point?

Mr. ROBERTS. I will tread with great care, I would say to my distinguished friend.

I thank the Senator for this colloquy. But you asked what it means that ''the Senate should reject any procedural maneuver that''—that is in quotes—and what does that really mean?

Well, it applies only to the Senate procedural motions. By itself it would have no effect on any substantive provision. That is the way it is commonly understood under Senate rules. It means, if adopted, the amendment would not remove any provision that has been identified as a tax increase on middle-class taxpayers, which is precisely what the Senator is trying to do. So basically it means nothing.

Mr. CRAPO. I think that is exactly the point we are trying to point out.

The next phrase in the amendment says, ''such as a motion to commit the pending legislation to the Committee on Finance.'' Remember, that is referring to the previous phrase that refers to a motion to increase taxes.

The only thing we need to say about this phrase is, there is a motion to commit the bill to the Finance Committee, but there is not a motion to commit the bill to the Finance Committee to raise taxes. It is to cut taxes.

The next phrase in the amendment is to suggest that there is an effort to try to kill the legislation.

Now, this is my motion. I suppose the implication there is, by trying to take the taxes out of the bill, we are trying to kill the legislation. What does that mean? Well, that means if you take the taxes out of this bill, that the bill does not stand. I assume that is what the amendment is trying to say. The reason that it does not stand is because they are saying the bill does not increase the deficit. Well, the only way you can say that the bill does not increase the deficit is if you do not bring into consideration the nearly $500 billion of cuts in Medicare, the nearly $500 billion of taxes which are being put on the people of this country, and the additional budget gimmicks that do not start counting the spending for 4 years, plus a number of other budget gimmicks.

So what they are saying is, you cannot take out one of the key legs of this bill, which is the way we raise all the money for this massive new spending, or else it will kill the bill. I think it is a pretty interesting fact that they have actually admitted in their own amendment what kind of games are being played.

Mr. ROBERTS. Will the Senator yield for a question?

Mr. CRAPO. Yes.

Mr. ROBERTS. That phrase that the Senator just mentioned is, ''which is designed to kill legislation.'' My question has already been answered by the distinguished Senator, what does it mean, but there are no motions that have been considered or pending, including the pending motion to commit by the distinguished Senator—is the motion designed to kill this legislation? Because that is what you are going to hear on the other side, and that is not the case.

Mr. BARRASSO. Madam President, it seems to me that what the Senator is doing with the Crapo amendment is actually trying to help people, trying to help the American people by taking this burden of $500 billion of taxes off of their backs, off of their shoulders, helping the American people. That is what I see he is trying to accomplish, at a time where with a gimmick they are going to start taxing immediately and when the taxes go into play—today is the 11th of December; in 20 days they are going to start collecting taxes for services they are not going to give for 4 more years. So it seems to me what is going on here with the Crapo amendment is it is saving the American people by keeping dollars in their pockets, keeping dollars in the pockets of the hard-working people of our country.

I am not the only one who is saying that. There is a new CNN poll out today that specifically asks the question—because the President has made a statement about the fact that you wouldn't see your taxes go up—Do you think your taxes would or would not increase if HARRY REID's bill is passed, and 85 percent of the American people in a CNN poll out today said they believe their taxes are going to go up; 85 percent of the American people.

Mr. CRAPO. I would say to my colleague from Wyoming that they are right, if this bill is not committed back to the Finance Committee to take those taxes out.

The next phrase in the amendment is—this is referring to a procedural motion, we call it—''that provides tax cuts for American workers and families.''

In other words, they don't want to send it back to committee to have a procedural motion put into place that would stop them from providing tax cuts for American families.

Again, it is rhetoric. Read the motion. The motion does not say to take out any benefits in the bill for anybody in America, unless you consider taxing people to be a benefit to them, but it simply says the taxes in the bill that are imposed on people that the President identified to be in the middle class and would be protected must be removed from the bill.

Mr. ROBERTS. Would the distinguished Senator yield for a question?

Mr. CRAPO. Yes.

Mr. ROBERTS. As Republicans, there is probably no principle that unifies us more than keeping taxes low on American workers and families, and I don't think our friends on the other side would dispute that notion. Indeed, the Democratic Party assumed control of the White House almost a year ago, as everybody knows, and seated large majorities here in the Congress. The one unmistakable distinction between the parties is this: Our party has respectfully opposed—I underline the word respectfully—opposed numerous efforts by the majority party to impose broad-based taxes increases on American workers and families. So one only need to look at the stimulus debate or the budget debate or the cap-and-trade legislation, and I could go on and on and on, more especially with the health care debate, and the bill before us.

Don't you follow from that general principle?

Mr. CRAPO. Absolutely. Again, I believe what is going on here with this new amendment is simply an effort to sort of divert attention from the real issue that is before the American people, the motion that was before the Senate, before we were forced by a procedural vote yesterday to move off the bill, and that is the question of the taxes in the bill.

The final phrase refers to a couple of the provisions in the bill that do have some support for improving the tax circumstances for small businesses and the affordability tax credit, meaning the tax credit that will be utilized to implement the subsidies for insurance.

Again, we can say it any number of times, but the fact is the motion they are trying to avoid does not deal with either of these provisions of the bill; it deals with those provisions in the bill that tax the American people.

Mr. BARRASSO. I am fine with voting on this, but it doesn't mean anything. I think it is absolutely meaningless, the Baucus amendment. I want to get to the heart of the matter, the meat of the matter, which is the Crapo amendment. That is the one I think makes the difference for the American people. If I were a citizen sitting at home watching C–SPAN on a Friday afternoon saying, what is going on in the Senate, what do I want, what is going to help me, I would say I want to call my Senator and say: Vote for the Crapo motion because that is the one that is actually going to help keep money in my pocket. The sense of the Senate? Oh, that is nice, but it is meaningless.

I am ready to vote right now for the Crapo motion because that is the one I think is going to help possibly save my job if I am at home and working. I am worried about unemployment in the country, I am worried about the taxes and the impact that is going to have. Because I worry if we don't get these taxes out of here, it is going to be a job killer for our Nation and for families all across this country, in Idaho, in Wyoming, in Kansas, in Kentucky. I think we have great concerns for the economy and the 10-percent unemployment. We need to get those taxes out of there now.

Mr. CRAPO. The Senator is, in fact, right. If you go back and try to get a little perspective on the entire debate, most Americans would agree that we need health care reform, but when they say that, they are talking about the need to control the skyrocketing costs of their health insurance and the costs of medical care, and they are talking about making sure we have real, meaningful access to quality health care in America.

In his statements, the President has many times commented about different parts of that. We remember when he said, If you like what you have, you can keep it. Well, we have seen that is not true, and there will be and have been already amendments to try to address those questions.

Remember when he said it is going to drive down the cost of health care and drive down your health care premiums? Well, we have learned now that it doesn't do that either; it actually drives up the cost of health care insurance and it is going to drive up the cost of medical care in this country.

Remember when he said you will not see your taxes go up? In fact, he pledged that if you were a member of the middle class, whom he defined as those making less than $250,000 as a couple or $200,000 as an individual, you would not see your taxes go up. Well, this motion is focused on that part of the debate. What did we see happen? Instead of letting us fix the bill, send the bill back to the Finance Committee to make the bill comply with the President's pledge, we saw two procedural maneuvers, one to maneuver off the bill, to get off the bill and move to the omnibus appropriations bill; secondly, to put up a bait-and-switch amendment that makes it look as though there is some kind of protection being put in place when, in reality, it is nothing more than a sense of the Senate relating to procedural motions that don't exist. I agree with my colleague from Wyoming and with my colleague from Kansas.

I see we have several of our other colleagues joining us here now. We need to keep the focus on health care and we need to keep the focus on those core parts of the bill that are critical to the American people.

Before I ask my colleague from Kansas if he wishes to make any other comments, I will reiterate the point that my colleague from Wyoming made with regard to the American people's understanding of this issue. In that CNN poll that I believe showed over 60 percent—I think it was 61 percent—of the people in this country who do not want this bill to move forward because they are now understanding what it does, in that same poll, 85 percent of the people in this country believe that this pledge of the President is broken by this bill.

Mr. ALEXANDER. I wonder if I might ask the Senator from Idaho and the Senator from Kansas, both the Senators are on the Finance Committee, I believe, and have been working on this health care bill for a long time. It is typical of a big, complex bill such as this that it is difficult to pass, and you get a sense every now and then of whether it is likely to pass or unlikely to pass. This week has been a particularly difficult week for the bill. I have noticed the majority leader trying to create a sense of inevitability about the bill.

But, increasingly, it seems to me, with it becoming clear that with so much of it being paid for by new taxes, and then last night the chief actuary of the Centers for Medicare and Medicaid Services saying the cost is going up, premiums are going up; with the Mayo Clinic saying it is beginning to not take Medicare patients, and the idea of putting millions more Americans into a program already going broke which you are taking $1 trillion out of is a bad idea; I wonder if in all—and all this talk about history being made and the inevitability of this bill, that the Senator from Idaho might not think, looking back over this whole debate, that maybe there are a lot of different ways to make it—that maybe a growing number of Senators might be thinking—not saying yet—might be thinking that this bill would be an historic mistake and that all the king's horses and all the king's men are not going to be able to push this up over the top.

Mr. CRAPO. The Senator from Tennessee is right, and he has put his finger on one of the key issues that is going on here in the Senate that sometimes isn't highlighted as closely as I think maybe it should be. That is, while we are talking about the need to make sure this bill does not raise taxes on the middle class, to make sure that the bill does not increase the cost of health insurance premiums, and to make sure that we maintain quality of health care and don't cut Medicaid and Medicare, the real battle here is an effort to create a legacy to essentially put the government in control of the health care economy. That is the debate. That is the legacy. That is the history that those who are pushing the bill are seeking to make, and they are seeking to make it at the expense of those on Medicare, of those of the taxpayers in America; and of the costs, the cost curve that they said they want to drive down, dealing with the cost of our health care.

I see our leader is here.

Mr. McCONNELL. I say to my friends from Tennessee and Idaho, December 11, 2009 may be remembered as the seminal moment in the health care debate for those who are writing about what finally happened on this issue. There were two extraordinary messages delivered on this very day on this health care issue. They were delivered from CMS and from CNN. CNN told us how the American people felt about it: 61 percent, as the Senator from Idaho pointed out, telling us please don't pass this bill. A week ago, Quinnipiac said 14 percent more disapproved than approved; the week before Gallup said 9 percent more disapproved than approved. We can see what is happening here: widening public opposition.

And then CMS, the actuary, the independent government employee who is an expert on this, says this bill, the Reid bill, doesn't do any of the things it is being promoted to accomplish. So two important messages on December 11 delivered from CNN and from CMS.

Mr. ROBERTS. Would the Senator yield?

Mr. CRAPO. Yes.

Mr. ROBERTS. I wish to thank our distinguished leader for pointing that out. It has been a seminal event. As I said before, I have the privilege of being chairman of the Rural Health Care Caucus. There are probably 30 of us in a bipartisan caucus to try to protect and improve the rural health care delivery system. I took that report by Mr. Foster, who is the actuary of CMS, and said, this is required reading. I made the point that if you mention CMS to a beleaguered hospital administrator or a member of the board or any medical provider—doctor, nursing home, home health care, hospice; even hospice is cut in regard to the cuts—they know if a CMS representative is knocking on the door, that is a lot like sending a cold shiver down their spine thinking it is Lizzie Borden. Of all of the agencies that now are shining the light of truth into darkness in regard to the nature of this bill in increased costs, and yes, rationing—no, it is not a scare tactic—CMS is that agency. It would be amazing if we could get CMS to report back on, if we knew what it was—the media reports are how we get the information on this new iteration of a bill where allegedly we are going to add in people from 55 years old into the Medicare system. You do that, and now all of a sudden even the national organizations, let alone the State provider associations who have been opposed to this, to say, Whoa, we can't do that. That is going to break the system.

What I wish to point out and what I think is another piece of information that has sort of been overlooked, the CBO has estimated the cost to the Internal Revenue Service to implement taxes and penalties and enforce them—I am talking about the IRS now, not CMS, but the IRS that is going to implement and administer and enforce taxes and penalties on the bill—that cost is $10 billion estimated by CBO. That would double the budget size of the IRS. We have to train these people, and then you have to figure out what kind of questions they are going to ask of employers and employees in regard to the fines and the fees, you have to read the fine print. The American people understand this tremendous tax increase is going to be administered by the IRS and that is not going to be a happy circumstance. But those two things that the leader has brought out are absolutely primary in this debate.

I think a side-by-side is a straw man. I think it is very clear about that. I am

happy to comment on that further. I wish to give others an opportunity to speak.

Mr. ALEXANDER. If I can make a short comment, I thank the Senator from Idaho for his leadership on taxes. But Senator MCCONNELL's comment about those two events on December 9—the poll from CNN and the report from the Centers for Medicare and Medicaid Services chief actuary—made me think about the immigration bill 2 years ago, in 2007. There were a lot of our best Senators working to pass comprehensive immigration bill, including Senators MCCAIN, KENNEDY, KYL, MARTINEZ, Members on both sides of the aisle, who worked very hard to do it. There seemed to be a sense of inevitability that that bill might pass. The President was even behind it.

But then it began to have so many problems, and the red flags began to pop up just like they are popping up with this comprehensive health care bill. There came a time, perhaps much like December 10, when the sense of inevitability was replaced by a sense that we were making a historic mistake, and a bill that got on the floor with 64 votes only had 46 to get off.

I have a feeling this bill, the more we learn about it, the wiser thing to do is to let it fall of its own weight. Then we can start over, step by step, to reearn the trust of the American people by reducing health care costs. We can do that. That is the sense I have.

I appreciate the Republican leader's observation about those important events on the 9th.

Mr. CRAPO. Mr. President, I agree with my colleagues. I think the comment of our leader is very insightful. As you start seeing the evidence mount, and the fact that the American public is understanding the weight of this mounting evidence about this legislation, we could be at the tipping point right now, where it has become so evident that the purpose behind health care reform has not only been missed by this legislation, but it has been made worse—the objectives.

I point to this chart, the cost curve. When you talk to most Americans about what they believe the purpose behind health care reform is, the vast majority say it is to control the skyrocketing costs. Well, those who are promoting the bill say it does that, it bends that cost curve. Which cost curve? Is it the size of government? That goes up $2.5 trillion in the first full 10 years of implementation. The cost of health care—the CMS report came out, it is about the 10th report, but this is from the actuary of the Medicare and Medicaid system who analyzed this independently, and he says health care costs are going to go up, not down.

The CBO said the cost of insurance is going to go up, not down. The Federal deficit—they say the bill doesn't make the Federal deficit go up. In fact, regarding that, the only way they can claim that is if they implement their budget gimmicks of delaying implementation of the bill for 4 years on the spending side, while raising taxes now, or if they raise hundreds of billions in taxes and cut Medicare by hundreds of billions of dollars.

These things are starting to be understood by the American people. That is why I believe we are starting to see those kinds of answers in the polls. It is not just the CNN poll, as the leader knows. Many polls are showing the American people get it.

Mr. ROBERTS. Will the Senator yield for another question?

Mr. CRAPO. Yes.

Mr. ROBERTS. I would like to get back to the side-by-side amendment allegedly being offered by the chairman of the Finance Committee, the Senator from Montana. I said straw man, and that is pretty harsh, but I intend it to be. We have seen how, if the language is examined, the amendment, at a minimum, is a red herring. You can fairly say the amendment, rather, has no other purpose than to facilitate a strong argument.

On Tuesday, when Senator CRAPO laid down his amendment, the majority didn't show us this side-by-side amendment until shortly before we thought—and they thought—we were going to vote. So that very limited notice makes you think it may be more likely to distract from or muddy the clear question the Senator from Idaho brought; that is, the motion to commit before the Senate. The motion was designed to be to be straightforward, and the Senator did that.

A vote for the motion is a vote to send the Reid amendment and underlying bill back to the Finance Committee. Under the motion, the Finance Committee would report back a bill that eliminates the tax increases on middle-income taxpayers. One could not say it anymore simply. That is what the motion does. The other bill is a straw man.

After the remarks by the distinguished leader, I would say this may be a seminal event. I think that is one of the key votes where the other side could start to realize this and start to finalize this without all the rhetoric and ideology and philosophical support for this bill, and they could start the road back, if you will, of doing it in a step-by-step, thoughtful way—doing it, meaning real health care reform.

I commend the Senator. Again, this side-by-side is a straw man. The Senator is clear in what he wants to do. Under the Senator's motion, the Finance Committee would report back a bill that eliminates the tax increases for middle-income taxpayers. We can restart the debate in a bipartisan way, where we can agree on many common goals. I thank the Senator.

Mr. CRAPO. I thank my colleague. Mr. President, how much time remains?

The PRESIDING OFFICER (Mr. REED). Thirty minutes.

Mr. CRAPO. I thank the Chair.

The PRESIDING OFFICER. Under the previous order, the Republican leader is recognized.

Mr. MCCONNELL. Mr. President, this follows along further with my colleagues who were discussing the CMS report.

Americans, of course, were told the purpose of reform was to lower costs, to bend the so-called cost curve down. But the report released last night by the administration's own independent scorekeeper, as we have been discussing on the floor of the Senate, shows the Reid bill gets a failing grade.

The chief actuary is the person the administration depends on to give its straightforward, unbiased analysis of the impact the legislation would have. This is an independent expert. It is the official referee, if you will. So this is quite significant.

According to CMS, the Reid bill increases national health spending. According to CMS, there are new fees for drugs, devices and insurance plans in the Reid bill and they will increase prices and health insurance premiums for consumers.

According to CMS, claims about the Reid bill extending the solvency of Medicare are based on the shakiest of assumptions.

According to CMS, the Reid bill creates a new long-term insurance program, commonly referred to around here as the CLASS Act, that CMS actuaries found faces a ''very serious risk of becoming unsustainable.''

The CMS found that such programs face a significant risk of failure.

The Reid bill pays for a $1 trillion government expansion into health care, with nearly $1 trillion in Medicare payment cuts.

All of this, I continue to be quoting from the CMS report.

The report further says the Reid bill is especially likely to result in providers being unwilling to treat Medicare and Medicaid patients, meaning a significant portion of the increased demands for Medicaid services would be difficult to meet.

The CMS actuary noted the Medicare cuts in the bill could jeopardize Medicare beneficiaries' access to care.

The CMS actuary also found that roughly 20 percent of all Part A providers—that is hospitals and nursing homes, for example—would become unprofitable within the next 10 years as a result of these cuts. As a result of those Medicare cuts, 20 percent of hospitals and nursing homes would become unprofitable within 10 years.

The CMS actuary found that further reductions in Medicare growth rates through the actions of the independent Medicare advisory board, which advocates have pointed to as a central linchpin in reducing health care spending, ''may be difficult to achieve in practice.''

The CMS further found the Reid bill would cut payments to Medicare Advantage plans by approximately $110 billion over 10 years, resulting in ''less

generous benefit packages'' and decreasing enrollment in Medicare Advantage plans by about 33 percent. That is a 33-percent decrease in Medicare Advantage enrollment over 10 years.

What should we conclude from this CMS report? The report confirms what we have known all along: The Reid plan will increase costs, raise premiums, and slash Medicare.

That is not reform. The analysis speaks for itself. This day, this Friday, as we were discussing yesterday, is a seminal moment. We have heard from CMS, the Government's objective actuary, the bill fails to meet any of the objectives we all had in mind. We also heard from CNN about how the American people feel about this package: 61 percent are opposed; only 36 percent are in support.

The American people are asking us not to pass this, and the Center for Medicaid Services' actuary is telling us it doesn't achieve the goals that were desired at the outset.

How much more do we need to hear? How much more do we need to hear before we stop this bill and start over and go step by step to deal with the cost issue, which the American people thought we were going to address in this debate?

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. CASEY. 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. CASEY. Mr. President, we are in our discussion of health care. We have been focused on a couple of major goals. The obvious goals that I think are a major part of the legislation we are debating are controlling costs, the goal of providing better quality of care, providing health care to millions of Americans—tens of millions, really—who would have no chance to get that kind of coverage without this legislation, and also the concern we have about not only controlling costs, but we have legislation on the floor that actually reduces the deficit by $130 billion and beyond the 10 years by hundreds of billions.

One of the concerns we have is that in the midst of a health care debate about numbers and the details of the programs is that we also do not forget that some parts of our health care system work well but often might need an adjustment or an amendment or a change that would benefit a vulnerable population of Americans who do not have the kind of coverage or protection or peace of mind they should have.

One of the more successful parts of our health care system as it relates to new parents, especially new mothers and new children, is what is known by the broad category of nurse home visitation programs. They have been enormously successful over many years.

I have an amendment I filed for this health care bill called the nurse home visitation Medicaid option amendment. It sounds a little complicated, but it is actually rather simple. It is part of what we need to do in the next couple of days and weeks as we complete our work on health care.

One point to make initially is that we know these nurse home visitation programs work. They get results for new parents, new mothers, and have positive benefits to a new mother and her children.

We all have had the experience, if we are parents, of the anxieties of what it is like to be a new parent but especially what a new mother goes through—all of the anxiety. It is not limited to one income group. No matter what income you are, no matter what background, it is a challenge to fully understand what it is like to have a baby and to care for that child appropriately. That is one of the underlying concerns we have.

In our health care system, we have to do everything possible to give that child a healthy start in life, and the best way to give a child a healthy start is to make sure his or her mother—and hopefully both parents—is able to handle the pressures and manage the anxieties that so many new parents have.

The amendment I filed supports optional nurse home visits. That means that if someone chooses not to take advantage of this program, obviously, they do not have to. The amendment simplifies the process for providers of nurse home visitation to seek Medicaid reimbursement. Some will say there is Medicaid reimbursement now. Yes, there is, but it gets complicated to a point where a lot of States are not getting the full benefit of that reimbursement. This amendment will impact the lives of Medicaid-eligible pregnant women and their children, and the impact is profound. The amendment is cosponsored by Senator GILLIBRAND of New York. It will allow States the option to seek more adequate reimbursement for nurse home visitation services. Again, a State is not forced to seek greater reimbursement, but I believe a lot of States could and should take advantage of this kind of an option.

In Pennsylvania, we have been trying to do this for years, even in the midst of having very effective nurse home visitation programs. One can just imagine how valuable that is for a new mother, that they can get advice and help from a nurse or another kind of professional and get them through the early days and weeks of being a new parent.

I believe a State such as Pennsylvania that has had a track record of these kinds of programs that have a direct and positive impact on children and their families, their mothers especially, should be able to take advantage of this, as I am sure many other States.

The amendment helps States cut through the redtape and allow these evidence-based nurse home visitation services—let me say those words again: ''evidence-based.'' This is not some theory; this is not some maybe—let's try to create a program. These programs work. The evidence is, in a word, irrefutable over many years that these nurse home visitation programs work. We want to allow States to be reimbursed under a State Medicaid option.

We have about 30 years of research to back up the following claims. Let me give four or five points.

We start with a category for every 100,000 families who are served by nurse home visitation programs or nurse-family partnership programs—all in that same category.

For every 100,000 families, 14,000 fewer children will be hospitalized for injuries and 300 fewer infants will die in their first year of life. That alone, that number alone is worth making sure States have this option. What is the price of saving 300 infants a year out of 100,000 families? It is incalculable. There is no value we could put on that kind of lifesaving as well as down the road saving money.

Let me give a couple of other examples.

For every 100,000 families served by these nurse home visitation-type programs, 11,000 fewer children will develop language delays by age 2. That is a profound impact on the child—his or her ability to achieve in school and then his or her ability to develop a high skill and therefore contribute positively to our economy. There is no price one can put on 11,000 new children learning more at a younger age.

Out of 100,000 families, 23,000 fewer children will suffer child abuse and neglect in the first 15 years of life. Again, there is no way we can quantify that with a number or budget estimate. But I would like to say we support strategies around here that are evidenced-based and scientifically based to make sure children are not abused, that they live through the first couple years of their lives when they are at risk of dying.

One more statistic. Out of the 100,000 families we use as a measurement, 22,000 fewer children will be arrested and enter the criminal justice system in the first 15 years of their lives. Just like the statistic about the first year of life and surviving the first year of life or not having in this case 23,000 more children suffer child abuse and neglect, these are impossible to measure. In a sense, it is the measure itself that we save children's lives, we make them healthier. They and their families are able to contribute more to society.

This is the right thing to do to give our States the option—just the option—of seeking greater reimbursement for these important services. I have seen it firsthand.

Many years ago—it must be at least 10 years ago—in Pennsylvania, I actually went to the home of a brand-new mother, a lower income mother in northeastern Pennsylvania. We walked

in the door, with her permission, with the nurse who was working with her after she left the hospital with her new baby. There is no way to put into words how valuable that relationship was between a new mother and a nurse, between a new mother and a health care professional to give her the start in any circumstance but especially if a new mother has financial pressures which are extraordinary and almost unbearable for some new mothers or has pressures as it relates to her husband or boyfriend, whoever is part of her life. Sometimes there is violence. Sometimes there are other pressures that some of us cannot even begin to imagine, in addition to the obvious pressure of being a new mother, being a new parent, and wanting to do the right thing.

These programs, as the evidence and science tell us, work to give new mothers peace of mind and to give States the ability to directly and positively impact the lives of that new mother and her child.

So we should give States this option, and that is why I urge my colleagues to support the nurse home visitation Medicaid option amendment.

Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. KYL. 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. KYL. Mr. President, I ask unanimous consent that following my remarks Senator BROWN of Ohio and then Senator LEMIEUX of Florida be recognized in that order.

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

Mr. KYL. Mr. President, each day it seems there is a new analysis of the Democratic proposal on health care that suggests it is not such a great idea. Today, a devastating report was made public by the Obama administration itself—the Department of Health and Human Services—and their group that is in charge of Medicare and Medicaid. It goes by the initials CMS. Specifically, the Chief Actuary, Richard S. Foster, of the Centers for Medicare and Medicaid Services, issued a report about the effect of the Reid legislation on health care as it pertains to a whole variety of things—the cost of the legislation, the effect it is going to have on taxes, on premiums, on benefits, the cost with respect to Medicare and the kinds of things that will occur to beneficiaries in Medicare, and so on. It is a complete report by a person who I think all would agree is not only qualified to speak to these things but also quite objective, as the chief actuary of CMS. He reached a number of very interesting conclusions, and I want to briefly discuss eight of them.

The first thing is that he noted his estimates were actually not a full 10-year estimate, and I will quote what he said here.

> Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the proposed legislation.

The reason that is important is we have been saying here for quite a long time that you can't just look at the first 10 years in order to see the full impact of this legislation because for the first 4 years most of the benefits don't exist. They are simply collecting taxes and fees and revenues, and then is when the benefits kick in, as a result of which, when they say it is all in balance, it is in balance because they are collecting money for 10 years but they only have to pay for benefits for 6 of those 10 years. So the real question is: What does it cost over the first full 10 years of implementation? And it turns out that is about $2.5 trillion.

We have known this, and we have made the point. I think even the chairman of the Finance Committee has acknowledged the $2.5 trillion if you take the first 10 years of implementation. But I think it is good to actually have that confirmed now by the Chief Actuary of CMS.

Secondly, a point I have been making all along is that when the President said repeatedly: If you like your insurance, you get to keep it, that is not true; and it is not true for a variety of reasons under the bill, and again this report confirms what we have been saying is in fact true; namely, that a number of workers who currently have employer-sponsored insurance would lose their coverage. In addition to that, seniors who are enrolled in private Medicare plans, which are known as the Medicare Advantage plans, would lose benefits, and many of them would no longer be covered.

Let me read two quotations, first relative to employer-sponsored insurance; and, second, people who are on Medicare Advantage plans. I am quoting now.

> Some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their and their employees' advantage to end their plans. The per-worker penalties assessed on nonparticipating employers are very low compared to prevailing health insurance costs. As a result, the penalties would not be a significant deterrent to dropping or forgoing coverage.

What does that mean? The employer under this bill has an obligation to provide insurance to his or her employees. If they don't do that, then they pay a penalty. The problem is that the penalty is much less than the cost of buying the insurance. So what we have been saying all along, and what the CMS actuary confirms here, is that in a lot of cases, small employers—and particularly companies with low average salaries—will find it to their advantage to drop the insurance coverage and have their folks go into the so-called exchange programs. The penalty these employers pay will be much less than what they are paying now to provide insurance.

So these folks who are very happy with the insurance they have right now are not going to be very happy when they get something substantially less than that through the so-called exchange. They may like the coverage they have now, but, unfortunately, what the President promised, that they would get to keep it, is not true. And this is confirmed by what I read to you.

What about folks on Medicare Advantage? These are senior citizens above 65 who are on Medicare, and what they have chosen to participate in is the private insurance coverage component of Medicare called Medicare Advantage. Here is the quotation.

> Lower benchmarks would reduce Medicare Advantage rebates to plans and thereby result in less generous benefit packages. We estimate that in 2015, when the competitive benchmarks would be fully phased in, enrollment in Medicare Advantage plans would decrease by about 33 percent.

Everybody has acknowledged there would be a reduction, but there has been little debate about how much it would be. Our initial projections are borne out by the CMS actuary—a decrease in enrollment in Medicare Advantage by about 33 percent. That is a third. This is important to me because 337,000 Arizonans participate in Medicare Advantage—almost 40 percent of all our seniors. And a third of them, if this works across the board, are going to lose their plan because of this. In any event, they are all going to lose benefits because of ''the result in less generous benefit packages.''

This hasn't been much in dispute, because the Congressional Budget Office itself has described precisely how much the benefit packages will be reduced by, and it is 90-some dollars. It is from 130-some dollars in actuarial value down to 40-some dollars in actuarial value, which is a huge reduction, obviously. So reduction in benefits; a third of the people no longer on Medicare Advantage. The bottom line, whether you are privately insured through your employer or you are a senior citizen in Medicare Advantage, you are not going to be able to keep the benefits and the plan you like and have, notwithstanding the President's commitment to the contrary.

Third, Medicare cuts. We have been talking a lot about Medicare cuts, and my colleagues on the other side say: Well, we don't think that the Medicare cuts are the way you describe them. Seniors are still going to have access to doctors and so on. This report is devastating in blowing a hole in that argument. Let me quote a couple of the things they say.

> Providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries).

This is what we have been predicting. If you impose extra costs and mandates

on the people who are providing the care—whether it be the hospitals, the physicians, home health care, or if you are taxing something such as medical devices—all of those impose costs on the people who are providing these medical benefits. What the CMS actuary is saying here is that the combination of those things would potentially jeopardize access to care for the beneficiaries. There aren't going to be as many of these people in business to provide care for an increasing number of people.

Let me go on with the quotation that I think will make this clear:

Simulations by the Office of the Actuary suggest that roughly 20 percent of Part A providers [hospitals, nursing homes, home health] would become unprofitable within the 10 year projection period as a result of the productivity adjustments.

In other words, 20 percent of the hospitals, home health care folks and others are not going to be profitable anymore. They are going to be out of business because of the burdens that are being placed upon them in this legislation. What happens when you have the baby boomers going into the Medicare Program? Under the latest idea from the other side of the aisle, we are even going to have 30 million potentially being able to join Medicare—the folks from 55 up to 65—but you are going to reduce by 20 percent the number of folks to take care of them—the hospitals and home health care and so on. Obviously, you have a big problem. Access will be jeopardized, as the actuary says.

This is where rationing, in effect, comes in. There simply aren't enough doctors, hospitals, and others to care for the number of patients who want to see them. This is how it starts. First, long delays, long lines, long waiting periods before you can get your appointment, and eventually denial of care because there is simply nobody to take care of you.

This is exacerbated by something else in the legislation, which is the fourth point here. The actuary talks about the independent Medicare advisory board. What is happening is that Medicare is being cut in three different ways: one, Medicare Advantage, which I mentioned; two, the providers are being slashed in the reimbursements that they are receiving; and three, this legislation creates an independent Medicare advisory board that is supposed to make recommendations on how to effect huge reductions in the cost of Medicare, and the primary way they will do that is by reducing the amount of money paid to doctors, to hospitals, to others who take care of patients. That, obviously, will also result in less care for the senior citizens.

If the cuts are so drastic that Congress says no, we are not going to do them, then you don't have the savings the bill relies upon to pay for the new entitlement. So one of two things happens, and they are both disastrous: Either you have these huge cuts, which are devastating for access to care or the cuts are so unrealistic they do not go into effect, in which case the legislation can't be paid for. And then I guess you are going to have to raise taxes on the American people because you aren't able to effect the savings from Medicare.

Here is what the actuary says:

In general, limiting cost growth to a level below medical price inflation alone would represent an exceedingly difficult challenge.

That is the challenge being put before them here—an exceedingly difficult challenge.

Actual Medicare cost growth per beneficiary was below the target level in only 4 of the last 25 years, with 3 of those years immediately following the Balanced Budget Act of 1997; the impact of the BBA prompted Congress to pass legislation in 1999 and 2000 moderating many of the BBA provisions.

What does that mean? In 1997, Congress passed the Balanced Budget Act, which drastically reduced the payments to these providers in order to cut the cost of Medicare. Three out of the four years in which the costs were reduced, it was immediately following that legislation. But starting in 1999 and into the year 2000, Congress realized those cuts were too deep; you were not going to get doctors and hospitals to continue to take care of patients if we continued to cut what they were paid for their services. So the cuts were ameliorated and, as a result, the savings were not achieved.

What the actuary is saying here is if that same thing happens again, if these cuts are so drastic we actually don't let them go into effect because they would be self-defeating, then you will not have the savings that have been promised and scored here as enabling this legislation to be so-called ''budget neutral.'' It won't be budget neutral. So as I said, one of two things will happen, and both are bad. Either you have the cuts, which are devastating for seniors or you don't have them and they are devastating to taxpayers.

Five is Medicare expansion. I think all of us agree on both sides of the aisle that Medicaid is a very vexing problem because the States have to pay for a percentage of the Medicaid patients and the States are generally in very poor financial shape and they do not need more people added to the Medicaid rolls that can't pay for them.

My Governor was in town earlier this week, and she said: Please, please, don't add people to the Medicaid rolls and expect the States are going to be able to pay for them. Let me read a couple of the quotes from this actuarial report.

Providers might tend to accept more patients who have private insurance (with relatively attractive payment rates) and fewer Medicare or Medicaid patients, exacerbating existing access problems for the latter group.

That latter group, of course, is the Medicaid group. The problem is that reimbursement is so low for Medicaid, frankly, they are the last patients a doctor sees, and their care is not the best. If we are going to provide care for a group of people, we need to do it right. Unfortunately, this is how rationing begins if you don't have enough money to do it right.

Then let me conclude with this quotation.

[This] possibly is especially likely in the case of the substantially higher volume of Medicaid services, where provider payment rates are well below average.

And that is my point.

Therefore, it is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years.

What they are saying is that there aren't going to be the physicians and the other people to care for the Medicaid patients here and, as a result, the promise we have made to these people we are not going to be able to keep.

Enrolling in Medicaid does not guarantee access to care by a long shot.

No. 6. Again, this is something we have been saying. This is not really too controversial because the Congressional Budget Office has said the same thing that the Actuary here says. But it is always good to have a backup opinion. This is the tax on drugs, on devices, and on insurance plans. We have all been saying of course those costs are passed on to the consumer in the form of higher premiums or, in a couple of cases, higher taxes. That is what is demonstrated:

Consumers will face even higher costs as a result of the new taxes on the health care sector.

I might just say before I read the quotation here, it doesn't make any sense to me why, in order to pay for this new entitlement, you would tax the very people you want to take care of. Tax the doctors, insurance companies, device manufacturers that make the diabetes pump or the stent for a heart patient or some other device that improves our health care these days? Let's tax them? I am saying maybe you want to tax liquor or tobacco or something, but why tax the things that make people healthier? Go figure. That is what the bill does.

Here is what the Actuary says:

We anticipate that such fees would generally be passed through to the health consumers in the form of higher drug and device prices and higher insurance premiums, with an associated increase of approximately $11 billion per year in overall national health expenditures, beginning in 2011.

Remember how we were going to drive costs down with this bill? We weren't going to be paying as much? The Actuary says:

We anticipate such fees would be generally passed through to the consumers in the form of higher drug and device prices and higher insurance premiums, with an associated increase of $11 billion a year.

This is going backward, not forward. The whole idea was to reduce costs and premiums. Instead, they are going up.

No. 7. Here is another tax. We are going to tax the higher premium plans. In response—this is a 40-percent tax on

these plans. What will employers do? According to the Actuary:

. . . employers will reduce employees' health care benefits.

That makes sense. If you are going to tax an insurance plan that has a lot of good benefits in it, then the employer is going to say: Rather than paying that tax, I will reduce the benefits—precisely what CMS says. This is another case in which if you like what you have, sorry, you are not going to get to keep it. We are going to tax it. Then the employer is going to reduce the benefits.

Here is the quotation from CMS:

In reaction to the excise tax, many employers would reduce the scope of their health benefits.

This is exactly what we have been saying.

Here are seven specific ways in which the CMS Actuary, working for the Obama administration Department of Health and Human Services, has verified the complaints Republicans have been making about this legislation for weeks—that it will raise premiums, it will raise taxes, it will raise costs. It will raise the cost of health care. It will raise the cost to the government. It will provide fewer benefits. It will result in the transition of people from private insurance to the exchange which is created in here and will result in less access to care because there will be fewer providers to take care of more people. What a wonderful reform.

This is why, when I talk about this legislation, I do not talk of health care reform. I am reminded of the line from a novel in which the individual says:

Reform, sir? Don't talk of reform. Things are bad enough already.

Indeed, they are. We do have problems. One of those problems is premium costs going up.

I note that my colleagues in the House of Representatives on the Republican side offered an amendment which, according to calculations of the Congressional Budget Office and according to the House Republicans, would have actually reduced premiums by $3,000 a year for the average family rather than increasing them. Republicans have good ideas about attacking the specific problems we face today. What we do not need is something under the guise of reform which is so massive, so intrusive into our lives and, with all due respect, not well thought out in terms of its long-range implications.

What you end up with at the end of the day, according to CMS now, according to the Actuary of the U.S. Government Health and Human Services, CMS, it raises premiums, raises taxes, reduces access to care, increases the cost, and provides fewer benefits. I cannot imagine how we could go home at Christmastime and say to our constituents: This is what we are giving you for Christmas this year.

The PRESIDING OFFICER. Under the previous order, the Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I rise to speak in opposition to a provision in the Patient Protection and Affordable Care Act that would impose a 40 percent excise tax on certain health insurance plans.

It is my strong belief that a benefits tax is the wrong way to pay for health reform legislation.

Beginning in 2013, this legislation would impose an excise tax of 40 percent on insurance companies and plan administrations for any health insurance plan that is above the threshold of $8,500 for singles and $23,000 for family plans.

The tax would apply to the amount of the premium in excess of the threshold.

This tax would not only be imposed on basic health benefits, it would be imposed if the combined value of basic benefits, dental benefits, and vision benefits reaches the $8,500 limit.

In other words, Americans would be better off without dental and vision coverage than with it.

How could a disincentive to dental and vision coverage be a good idea? The answer is, ''it's not.''

In subsequent years, increases in the benefit thresholds will be tied to the consumer price index plus one percent.

What this means is that more and more workers and employers will be affected in subsequent years.

In fact, the Congressional Budget Office, CBO, estimates that, by 2016, this benefits tax would affect 19 percent of workers with employer-provided health coverage.

CBO further projects that revenues resulting from the tax would increase by 10–15 percent every year in the second decade after the tax takes effect.

And though this appears to be a tax on insurance companies, we should not be fooled.

Insurance companies are likely to pass these costs onto their customers—forcing employees to pay higher premiums or encouraging employers to cut or limit coverage.

Health reform legislation should not penalize middle-income Americans who have forgone salary and wage increases in return for more generous health benefits.

I remember, as the Presiding Officer in his leadership in the Banking Committee remembers, during the auto discussions, when President Bush first moved to help the auto companies that were under such duress, many people on the other side of the aisle saw the legacy costs as something bad, the legacy costs the auto companies had. In fact, these legacy costs were benefits negotiated by unions. Those workers had been willing to give up present-day wages to have better health insurance and better pensions. This is the same kind of issue.

And health reform legislation should not encourage the elimination of existing health benefits.

Instead, health reform legislation should ensure that Americans who have negotiated good health benefits—including dental and vision coverage—are able to keep those benefits without punishment.

I have heard many of my colleagues argue that this excise tax will ''bend the cost curve'' of health care costs and expenditures.

However, the Commonwealth Fund found that ''there is little empirical evidence that such a tax wcould have a substantial effect on health care spending.''

And is makes no sense to bend the cost curve by compromising access to needed health services now—leading to higher health care costs later.

You are squeezing on a balloon, not changing the long-term trajectory of health spending.

To bend the cost curve, we need to identify and reward the provision of the right care, in the right settings, at the right time.

We need to target duplication, promote best practices, and clamp down on those who overprice health insurance and health care products and services—exploiting their role in ensuring the health of the American people.

We need to give Americans more purchasing power and inject more competition into the health care marketplace.

We don't need to reverse the clock on health care progress by discouraging Americans from having good health coverage.

There is so much that is critically important in health reform legislation—from delivery system reforms to prevention and wellness initiatives to provisions which strengthen Medicare to making insurance more affordable and accessible for all Americans—but this counterproductive tax on middle-income Americans is not a provision I can support.

That is why I have cosponsored an amendment with Senator SANDERS of Vermont that would eliminate this benefits tax and instead impose a surtax on the very wealthiest earners—those who benefitted so much from the Bush-era tax cuts.

Our amendment, as modified, would replace the benefits tax on health insurance plans with a 5.4 percent surtax on adjusted gross income for individuals who earn more than $2.4 million a year and couples who earn more than $4.8 million per year.

Instead of taxing middle class Americans for having good health coverage, our amendment would help address the disproportionate impact of the Bush tax cuts—which were outrageously tilted toward the wealthiest of the wealthy.

Multimillionaires and billionaires fared far better than middle-class families under the Bush Administration. Let's not continue that tradition in this Congress.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Florida.

Mr. LEMIEUX. Mr. President, it is always good to follow my colleague from

Ohio. I rise to speak about the health care bill. I, specifically, wish to speak about this new report we have received from the Office of the Actuary from the Centers for Medicare & Medicaid Services. This report, unfortunately, confirms many of the problems we already knew. This report comes from an independent actuary who works in the very agencies that have to implement our Federal health care programs. This actuary has reviewed the proposal before us, the proposal that is intended to be health care reform. The review and report of this actuary shows significant problems with this proposal and why we must start over and take a step-by-step approach.

I had the opportunity to read this report this afternoon in my office, word for word, and go through it line by line. I hope all my colleagues do on both sides of the aisle. There are many troubling things this report shines light upon. First, the proposal we are debating increases the cost of health care. For Americans who are at home and might be watching this to see various Senators on the floor of this great body, they think the reason we are here is to reduce the cost of health care and to promote more access. Those are the two big goals. That is what the President told us. We are going to lower the cost of health care. This report shows, national health care expenditures are going to go up from 16 percent of the gross domestic product to 20 percent.

The chief actuary says, on page 4 of this report, we are going to spend $234 billion more on health care over the next 10 years. We are going to spend more on health care. We are not going to reduce costs. We are going to increase costs.

Moreover, the Federal Government, in its provision of health care, is going to spend $366 billion more in health care provisions. We are told this proposal is budget neutral or it actually creates less of a deficit. It cuts the deficit of the Federal budget. But as has been revealed this week—and this is just gimmickry—the taxes start before the benefits. For 4 years, we pay the taxes and the benefits don't start until 2014. So 4 years of penalties without any benefits. This is similar to if you were to go buy a home and you went to buy the home and you said: We are going to live here for the next 10 years, and the real estate agent said to you: That is fine. You are just going to pay for the first 4 years, but you don't get to move in until 2014.

For families sitting around the kitchen tables, that is not how they balance their budgets. But that is this strange world that Washington is, that you can set up this budget gimmickry in order to get it to so-called budget neutrality. The actuary of CMS recognizes that. He says, on page 2, most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period.

> The cost estimates shown in this memorandum do not represent a full 10-year cost of the proposed legislation.

It is not budget neutral. It is just a gimmick.

The second problem the actuary points to is, it jeopardizes access to care for seniors. My colleagues have been saying this for the past couple weeks. You can't take $½ trillion out of Medicare and have it not hurt the provision of health care for seniors. This plan is going to gut Medicare as we know it. It severely cuts funding for Medicare.

In this report, it goes through all the cuts to Medicare Advantage, to home health, to hospice. The actuary goes through all these cuts. What does the actuary conclude is going to be the result? Our friends on the other side of the aisle say this is not going to cut Medicare; it is going to save Medicare. How do you take $½ trillion out and save Medicare? The actuary understands it. He knows that doctors who provide services under Medicare for seniors or for the poor under Medicaid aren't going to take these reimbursements anymore. They will not see people and provide health care. So it is not health care reform if the doctor will not see you.

Right now, in this country 24 percent of doctors aren't taking Medicare; 40 percent are not taking Medicaid. The actuary says providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program, possibly jeopardizing access to care for beneficiaries.

The second reason we are doing health care reform, access to care, is going to be hurt for seniors by this bill. That is on page 9, for those who are following at home. By the way, we are going to put this report on our Web site at lemieux.senate.gov. If you want to read it, you can read all the details.

The next thing the actuary discovers as a problem with this bill is that for the 170 to 180 million Americans who have health insurance, your premiums are going to go up, not down. We are not going to bend the cost curve down. Health care will be more expensive, more expensive than if we were to do nothing and not implement this bill at all.

The chief actuary says premiums for the government-run plan, for example, would be 4 percent higher than for private insurers. So we don't achieve that goal. What is going to happen when we put all this burden on businesses? Because we know that under this program we are going to penalize businesses if they don't provide health insurance. We are going to penalize individuals if they don't provide health insurance. So what are small businesses going to do who are hardly making it now? In Florida, we have 11 percent unemployment. Our small businesses are suffering.

The actuary says on page 7, some small employers would be inclined to terminate their existing coverage. So they will drop their health insurance. You are an employee in a small business, they drop your health insurance. Now you must go buy the Federal program, where you will be subsidized. What does that mean? It means every man and woman will be paying taxes to help pay for health care insurance, taxes we can't afford, spending we can't afford, not in a world where we have a $12 trillion budget deficit. We are just pushing the cost off on our children and grandchildren. That is when this deficit is going to come home to roost.

The actuary also says the excise tax on high cost employer-sponsored health insurance is going to cause employers to scale back coverage. So if you have one of the better health care plans, the Cadillac plans, your employer will not be incentivized to give you less coverage, less benefits, less access. Is that what we thought reform was supposed to be?

Now we also know from the actuary we are going to raise taxes in this bill. As my friend, the Senator from Arizona, was saying, we are going to tax device makers. We are going to tax pharmaceutical companies, the implements and devices and medicines that save our lives. We know there is $64 billion in penalties in this bill. The actuary says, on page 5, if you are a small business or you are an individual and you don't provide the insurance, you are going to be taxed, penalized, $64 billion in penalties.

The actuary says:

> We anticipate that such fees would generally be passed to health consumers—

These are the taxes on the devices and the drugs—

> in the form of higher prices and higher insurance premiums.

I also wish to address one point before concluding. My friends on the other side have been saying there are not going to be any cuts to benefits because we will run a more efficient system. There is going to be less fraud and abuse and waste.

We all want that. That makes a lot of sense. But the actuary, in evaluating this—and he talks about it on page 12—finds that the cuts and the reductions are negligible. In fact, he can't even sufficiently provide evidence to know what the estimates of savings might be; at best, $2.3 billion for all the efficiency and savings. Remember, this is a $2.5 trillion program. There is $2.3 billion in savings, like 1 percent. So it is not the efficiency that is going to make up the cuts; it is going to be a cut in benefits to seniors. It will be higher insurance premiums for Americans. That is not health care reform.

It is why the Wall Street Journal called this bill the worst bill ever. In talking about this new proposal to expand Medicare and drop the age for Medicare, this morning the Wall Street Journal corrected itself and said that is even worse than the worst bill ever.

Similar to the Presiding Officer, I am new to this Chamber. I have been here

about 90 days. It is a great honor to serve in the Senate, representing 18 million people from Florida, but it is also a little bit frustrating. The way the Senate works is not the real world. It is not like moms and dads who sit around the kitchen table and try to figure out how to make ends meet and they can only spend as much money as they take in. That is not how we work in this institution. We don't work in a reasonable way.

My colleague from Utah will speak in a minute. He was on the floor the other night talking eloquently about how, when you do real reform, you get 80 Senators to vote on a proposal. If this bill passes, 60 Democrats will vote for it, 40 Republicans will not. If just one Democrat would feel their conscience and not vote for this bill, we could start over. We could work together in a bipartisan way and help those 45 million Americans who don't have health insurance. But we wouldn't do it by robbing from Medicare. We wouldn't do it by raising taxes. We wouldn't do it by creating a $2.5 trillion new program.

I have struggled to try to figure out a way to explain to the people how bad this bill is. I know it is hard. You are sitting at home, around the kitchen table, trying to understand what Washington is up to. It is hard to understand. I have thought about cultural references and historical references, maybe even things in pop culture that I could use as an analogy to try to explain what is going on in the Senate. The only thing I can think of is the ''Wizard of Oz.'' In the ''Wizard of Oz,'' Dorothy gets thrown into the tornado in sort of an alternate reality, a place that doesn't play by the same rules. That is sort of the Congress. Dorothy and the lion and the tin man and the scarecrow are told: Follow the yellow brick road, you will get there. All your answers will be solved. Everything will be great.

That is sort of like this phrase we hear around here: Make history, make history, just get it done. Pay no attention to the cuts in Medicare. Pay no attention to the Medicaid you will put on the States that can't afford it. Pay no attention to the higher taxes and the higher premiums people will have to suffer under. Similar to the scarecrow, who doesn't have a brain, it is not very thoughtful to put more expenses and more taxes on the States with Medicaid when they can't afford it. Similar to the tin man, who doesn't have a heart, it is not very thoughtful to take money out of health care for seniors. Similar to the lion, who has no courage, we don't have the courage to do what is right and work together in a bipartisan way. When you get to the end of the yellow brick road and you get to Oz, you find out there is nothing behind the curtain.

This isn't health care reform. We need to start over, and we need to get it right.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I appreciate the remarks of my distinguished colleague from Florida. People need to listen to him. I am grateful to have him in the Senate, a fine man he is and a good example to all of us. I appreciate his remarks.

I rise to explain why I believe the Reid health care bill is not only bad policy for this country but also undermines the Constitution and the liberty it makes possible. I urge my colleagues to resist two errors that can distort our judgment and lead us down the wrong path. Those errors are assuming that the Constitution allows whatever we want to do and ignoring this question altogether.

We have only the powers the Constitution grants us because liberty requires limits on government power and we have our own responsibility to make sure we stay within those limits.

James Madison said that if men were angels, no government would be necessary, and if angels were to govern men, no limits on government would be necessary. Because neither men nor the governments they create are angelic, government and limits on government are both necessary to protect liberty—not just government but limits on government as well. Those limits come primarily from a written Constitution which delegates enumerated powers to the Federal Government.

Here is how the Supreme Court put it just a few years ago. This is in United States v. Morrison in 2000, quoting Marbury v. Madison—one of the most important decisions ever by the Supreme Court, probably the single most important decision—back in 1803:

> Every law enacted by Congress must be based on one or more of its powers enumerated in the Constitution. ''The powers of the legislature are defined and limited; and that those limits may not be mistaken or forgotten, the constitution is written.''

The important word there happens to be ''limits.''

No one likes limits, least of all politicians with grand plans and aggressive agendas. It is tempting to ignore or forget the limits the Constitution imposes on us by pretending the Constitution means whatever we want it to mean. But we take an oath to support and defend the Constitution, not to make the Constitution support and defend us. The Constitution cannot limit government if government controls the Constitution.

In April 1992, during a debate on welfare reform legislation, the senior Senator from New York, Mr. Moynihan, with whom I served, made a point of order that an amendment offered by a Republican Senator was unconstitutional. Here is what Senator Moynihan said:

> We do not take an oath to balance the budget, and we do not take an oath to bring about universal peace, but we do take an oath to protect and defend the Constitution of the United States.

Applying that sage advice today, we do not take an oath to reform the health care system or to bring about universal insurance coverage, but we do take an oath to protect and defend the Constitution of the United States.

For the past 8 years, my friends on the other side of the aisle insisted that the Constitution sets definite and objective limits that the President must obey. The Constitution, they said, does not mean whatever the President wants it to mean. Compelling circumstances or even national crises, they said, cannot change the fact that the Constitution controls the President, not the other way around.

It is easy to insist that the Constitution controls another branch of government, that the Constitution does not mean whatever another branch of government wants it to mean. The real test of our commitment to liberty, however, is our willingness to point that same finger at ourselves.

I ask my colleagues, is the Constitution rock solid, unchanging, and supreme for the executive branch but malleable, shape-shifting, and in the eye of the beholder for the legislative branch?

A principle applied only to others is just politics, and politics alone cannot protect liberty. We must be willing to say that there are lines we may not cross, means we may not use, and steps we may not take.

The Constitution empowers Congress to do many things for the American people. Just as important, however, is that the Constitution also sets limits on our power. We cannot take the power without the limits.

I want to address several constitutional issues raised by this legislation.

The first is the requirement in section 1501 that individuals obtain not simply health insurance but a certain level of insurance. Failure to meet this requirement results in a financial penalty which is to be assessed and collected through the Internal Revenue Code.

We hear a lot about how Senators on this side of the aisle are supposedly defending the big, evil insurance companies, while those on the other side of the aisle are defenders of American families. This insurance mandate exposes such partisan hypocrisy.

Let me just ask you one simple question. Who would benefit the most from the unprecedented mandate to purchase insurance or face a penalty enforced by our friends at the Internal Revenue Service? The answer is simple. There are two clear winners under this Draconian policy and neither is the American family. The first winner is the Federal Government, which could easily use this authority to increase the penalty or impose similar ones to create new streams of revenue to fund more out-of-control spending. Second, the insurance companies are the most direct winners under this insurance mandate because it would force millions of Americans who would not otherwise do so to become their customers. I cannot think of a bigger

windfall for corporations than the Federal Government ordering Americans to buy their products.

Right now, States are responsible for determining the policies that best meet the particular demographic needs and challenges of their own residents. That is the States. Massachusetts, for example, has decided to implement a health insurance mandate, while Utah has decided not to do so. This bill would eliminate this State flexibility so that the Federal Government may impose yet another one-size-fits-all mandate on all 50 States and on every American. I cannot think of anything more at odds with the system of federalism that America's Founders established, a system designed to limit government and protect liberty.

I can understand why this mandate is so attractive to those who believe in an all-powerful Federal Government. After all, raising the percentage of those with health insurance is easy by simply ordering those without insurance to buy it. But while government may choose the ends, the Constitution determines the permissible means. That is why one of the basic principles is that Congress must identify at least one of our powers enumerated in the Constitution as the basis for any legislation we ultimately pass.

The health insurance mandate is separate from the penalty used to enforce it. The only enumerated power that can conceivably justify the mandate is the power to regulate interstate commerce. For more than a century, the Supreme Court treated this as meaning what it says. Congress cannot use its power to regulate commerce in order to regulate something that is not commerce. Congress cannot use its power to regulate interstate commerce in order to regulate intrastate commerce.

In classic judicial understatement, the Supreme Court has said that ''our understanding of the reach of the commerce clause . . . has evolved over time.'' Indeed, it has. Since the 1930s, the Supreme Court has expanded the power to regulate interstate commerce to include regulating activities that substantially affect interstate commerce. That is obviously far beyond, by orders of magnitude, what the commerce power was intended to mean, but that is where things stand today, and some say it justifies this health insurance mandate in this bill.

Using the Constitution or even the Supreme Court's revision of the Constitution as a guide requires more than a good intention fueled by an active imagination. The Supreme Court has certainly expanded the category of activities—get that word ''activities''—that Congress may regulate. But every one of its cases has involved Congress seeking to regulate just that: activities in which people have chosen to engage. Even the Supreme Court has never abandoned that category altogether and allowed Congress instead to require that individuals engage in activities, in this case by purchasing a particular good or service. The Court has never done that.

Let me mention just three of the Supreme Court's commerce clause cases. In its very first case, Gibbons v. Ogden in 1824, Thomas Gibbons had received a Federal license to operate a steamboat between New Jersey and New York and wanted to compete with Aaron Ogden, who had been granted a steamboat monopoly by New York State. In Wickard v. Filburn, Roscoe Filburn used the winter wheat he planted on his Ohio farm to feed his livestock and make bread for his own dinner table. In the winter of 1942, he grew more wheat than allowed under the Agricultural Adjustment Act and challenged the resulting fine. And in Hodel v. Surface Mining & Reclamation Association, companies challenged a Federal statute regulating surface coal mining.

These cases have two things in common. The Supreme Court upheld Federal authority in each case, but each case involved an activity—remember the word ''activity''—in which individuals chose to engage. There would have been no Gibbons v. Ogden if Thomas Gibbons had not chosen to operate a steamboat. Congress could regulate his activity but could not have required that he engage in it. There would have been no Wickard v. Filburn if Roscoe Filburn had not chosen to grow wheat. Congress could regulate his activity but not have required that he engage in it. And there would have been no Hodel case if companies had not chosen to mine coal. Congress could regulate their activity but could not have required that they engage in it.

The key word in the commerce clause is the word ''regulate,'' and the key word in every Supreme Court case about the commerce clause is the word ''activity.'' Regulating an activity in which individuals chose to engage is one thing; requiring that they engage in that activity is another.

The Congressional Budget Office examined the 1994 health care reform legislation which also included a mandate to purchase health insurance. Here is the CBO's, the Congressional Budget Office's, conclusion. This is August 1994, the Congressional Budget Office:

> A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy a particular good or service. . . .Federal mandates typically apply to people as parties to economic transactions, rather than members of society.

That is pretty important language. In other words, Congress can regulate commercial activities in which people choose to engage but cannot require that they engage in those commercial activities.

Just a few months ago, as Congress once again is considering a health insurance mandate, the Congressional Research Service examined the same issue. Here is what the Congressional Research Service concluded. This was in July 2009. The CRS concluded:

> Whether such a requirement [to have health insurance] would be constitutional under the Commerce Clause is perhaps the most challenging question posed by such a proposal, as it is a novel issue whether Congress may use this clause to require an individual to purchase a good or service.

Can Congress use this clause to require an individual to purchase a good or service?

One thing did change in the legal landscape between 1994, when CBO called the health insurance mandate ''unprecedented,'' and 2009, when CRS called it ''novel.'' The Supreme Court twice found that there are limits to what Congress may do in the name of regulating interstate commerce.

In United States v. Lopez, the Court rejected a version of the commerce power that would make it hard ''to posit any activity by an individual that Congress is without power to regulate.''

If there is no difference between regulating and requiring what people do, if there is no difference between incentives and mandates, if Congress may require that individuals purchase a particular good or service, why did we even bother with the Cash for Clunkers Program? Why did we bother with TARP or other bailouts? We could simply require that Americans buy certain cars or appliances, invest in certain companies, or deposit their paychecks in certain banks. For that matter, we could attack the obesity problem by requiring Americans to buy fruits and vegetables and to eat only those.

Some say that because State governments may require drivers to buy car insurance, the Federal Government may require that everyone purchase health insurance. That is too simplistic, that argument. Simply stating that point should be enough to refute it. States may do many things that the Federal Government may not, and if you do not drive a car, you do not have to buy car insurance. This legislation would require individuals to have health insurance simply because they exist, even if they never see a doctor for the rest of their lives.

The defenders of this health insurance mandate must know that they are on shaky constitutional ground. The bill before us now includes findings which attempt to connect the mandate to the Constitution. I assume they are the best arguments that this unprecedented and novel mandate is constitutional.

Those findings fail in at least four ways.

First, the findings say that the requirement to purchase health insurance will add millions of new consumers to the health insurance market. I cannot dispute the observation that requiring more people to purchase health insurance will result in more people having health insurance. I think that seems quite self-evident. But the question is not the effect of the mandate but the authority for the mandate. Liberty requires that the ends cannot justify the means. The findings

also fail to establish that the insurance mandate is constitutional by failing to offer a single example—a single precedent, a single case—in which Congress has required individuals to purchase a particular good or service or the courts have upheld such a requirement. The cases I described are typical, and similar examples are legion. Every one involves—every one of those cases I have cited—the regulation of activity in which individuals choose to engage. Requiring that the individual engage in such activity is a difference not in degree but in kind.

The findings also fail to answer the question by observing that States such as Massachusetts have required that individuals purchase health insurance. As I noted regarding the example of car insurance, our Federal and State system allows States to do many things that the Federal Government may not. That is one of those limits on the Federal Government that is necessary to protect liberty.

The findings fail to answer the question by mistakenly focusing on whether Congress may regulate the sale of insurance. That misses the point in two respects. Simply because Congress may regulate the sale of health insurance does not mean that the Congress may require it. Simply because Congress may regulate the sale of health insurance does not mean that Congress may regulate the purchase of health insurance. This legislation requires you to believe that nonactivity is the same as activity; that choosing not to do something is the same as choosing to do it; that regulating what individuals do is the same as requiring them to do it. That notion makes no common sense, and it certainly makes no constitutional sense. If Congress can require individuals to spend their own money on a particular good or service simply because Congress thinks it is important, then the Constitution means whatever Congress says it means and there are and will be no limits to the Federal Government's power over each and every one of our lives.

That version of Federal power will be exactly what the Supreme Court in Lopez prohibited; namely, that there would be no activity by individuals that the Federal Government may not control. Neither the power to regulate interstate granted by the Constitution nor the power to regulate activities that substantially affect interstate commerce granted by the Supreme Court go that far. They don't go that far.

The American people agree. A national poll conducted last month found that 75 percent of Americans believe that requiring them to purchase health insurance is unconstitutional because Congress's power to regulate commerce does not include telling Americans what they must buy. By a margin of more than 7 to 1, Americans believe that elected officials should be more concerned with upholding the Constitution regardless of what might be popular than enacting legislation even if it is not constitutional.

Some defenders of this legislation such as the House majority leader have said that Congress may require individuals to purchase health insurance because it can pass legislation to promote the general welfare. The only thing necessary to dismiss this argument is to read the Constitution. Read the Constitution. That dismisses this argument. Just read it. Read the Constitution. Article I refers to general welfare as a purpose, not as a power. It is a purpose that limits rather than expands Congress's power to tax and to spend. The requirement that individuals purchase health insurance is not an exercise of either the power to tax or the power to spend, and so even the purpose of general welfare is not connected to it at all. Needless to say, it makes no sense to include in a written Constitution designed to limit Federal Government power an open-ended, catchall provision empowering Congress to do anything it thinks serves the general welfare.

If America's Founders wanted to create a Federal Government with that much power, they could have written a much shorter Constitution, one that simply told Congress to go for it and legislate well. That is what they could have done. They didn't do that, thank goodness.

The Heritage Foundation has just published an important paper arguing that this health insurance mandate is both unprecedented and unconstitutional. It is authored by Professor Randy Barnett, the Cormack Waterhouse Professor of Legal Theory at the George Washington Law Center; Nathaniel Stewart, an attorney with the prestigious law firm of White & Case, and Todd Gaziano, Director of the Center for Judicial and Legal Studies at the Heritage Foundation.

I ask unanimous consent to have the conclusion portion of the Legal Memorandum published by the Heritage Foundation printed in the RECORD.

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

CONCLUSION

In theory, the proposed mandate for individuals to purchase health insurance could be severed from the rest of the 2,000–plus-page ''reform'' bill. The legislation's key sponsors, however, have made it clear that the mandate is an integral, indeed ''essential,'' part of the bill. After all, the revenues paid by conscripted citizens to the insurance companies are needed to compensate for the increased costs imposed upon these companies and the health care industry by the myriad regulations of this bill.

The very reason why an unpopular health insurance mandate has been included in these bills shows why, if it is held unconstitutional, the remainder of the scheme will prove politically and economically disastrous. Members need only recall how the Supreme Court's decision in Buckley v. Valeo—which invalidated caps on campaign spending as unconstitutional, while leaving the rest of the scheme intact—has created 30 plus years of incoherent and pernicious regulations of campaign financing and the need for repeated ''reforms.'' Only this time, the public is aligned against a scheme that will require repeated unpopular votes, especially to raise taxes to compensate for the absence of the health insurance mandate.

These political considerations are beyond the scope of this paper, and the expertise of its authors. But Senators and Representatives need to know that, despite what they have been told, the health insurance mandate is highly vulnerable to challenge because it is, in truth, unconstitutional. And political considerations aside, each legislator owes a duty to uphold the Constitution.

Mr. HATCH. I also wish to share with my colleagues a letter I received from Dr. Michael Adams and attorney Carroll Robinson. They are on the faculty of the Barbara Jordan Mickey Leeland School of Public Affairs at Texas Southern University. Mr. Robinson, a former member of the Houston City Council, was named by the Democratic Leadership Council in 2000 to its list of ''100 to Watch.''

I ask unanimous consent their entire letter, which is dated October 25, 2009, be printed in the RECORD following my remarks.

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

(See exhibit 1.)

Mr. HATCH. Let me share just an excerpt from these two people. This is an excerpt from Michael Adams, Ph.D., and Carroll G. Robinson, Esquire, from the Barbara Jordan and Mickey Leland School of Public Affairs, Texas Southern University:

Our reading of the Constitution and Supreme Court precedent could not identify any reasonable basis, expressed or implied, for granting Congress the broad, sweeping and unprecedented power that is represented by the individual mandate requirement. In fact, we could not find any court decision, state or federal, that said or implied that the Constitution gave Congress the power to mandate citizens buy a particular good or service or be subject to a financial penalty levied by the government for not doing so.

That is pretty impressive stuff.

It is certainly possible to achieve the goal of greater health insurance coverage by constitutional means, not unconstitutional means. I am quite certain, however, that those means are politically impossible.

Liberty requires that the Constitution trump politics, but in the legislation before us, politics trumps the Constitution.

Another provision in this legislation that is inconsistent with the Constitution is section 9001, which imposes an excise tax on high-cost employer-sponsored insurance plans differently in some States than in others. The legislation imposes a tax equal to 40 percent of benefits above a prescribed limit but raises that limit in 17 States to be determined by the Secretaries of the Treasury and Health and Human Services.

My colleague from Ohio, Senator BROWN, spoke against this provision on policy grounds earlier.

The Constitution allows Congress to impose excise taxes but requires that

they be ''uniform throughout the United States.'' This is one of those provisions that will be dismissed with pejorative labels such as archaic by those who find it annoying. But it is right there in the same Constitution that we have all sworn to uphold. We have all sworn that same oath to protect and defend, and we are just as bound today to obey it.

Frankly, a good test of our commitment to the Constitution is when we must obey a provision that limits what we want to do.

The Supreme Court has had relatively few opportunities to interpret and apply the uniformity clause, but its cases do provide some basic principles which I think easily apply to the legislation before us today. The Court has held, for example, that a Federal excise tax must be applied ''with the same force and effect in every place where the subject of it is found.''

The Congress has wide latitude in determining what to tax and may tailor a regional solution to a geographically isolated problem, but laws drawn explicitly in terms of State lines will receive heightened scrutiny. By the plain terms of the legislation before us, insurance plans providing a certain level of benefits in one State will be taxed while the very same plans providing the very same benefits in another will not be taxed. We do not yet know what States will be treated differently, but we do know, according to this bill, that 17 of them will. That actually makes the constitutional point more clearly by identifying the State-based discrimination more starkly. Congress may decide to tax insurance plans with benefits that exceed a particular limit, but the tax must have the same force and effect wherever that subject of the tax is found. That is the clear meaning of the constitutional provision and the clear holding of the Supreme Court's precedents. Taxing the same insurance plans differently in one State than in another is the opposite of taxing them uniformly throughout the United States.

I commend to my colleagues the work of Professor Thomas Colby of the George Washington University Law School, whose comprehensive work on the uniformity clause was published in volume 91 of the Virginia Law Review.

I asked the Congressional Research Service to look at this uniformity clause issue. Its report confirmed that this differential tax on high-cost insurance plans is drawn explicitly along State lines and that a court will more closely scrutinize the reasons for the State-based distinction. It also concluded that Congress has not articulated any justification for singling out certain States for different treatment. I have raised this issue over and over throughout the process of developing and considering this legislation. I serve on both of the Senate committees that are involved in this process. In fact, I can say I have served on three: not only the HELP Committee—the Health, Education, Labor and Pensions Committee—but also the Finance Committee, as well as the Judiciary Committee that, for some reason, has some great interest in the Constitution. I have never heard any justification for singling out certain States for different tax treatment.

The attitude seems to be that this is what the majority wants to do, so they are going to do it no matter what the Constitution says. That may be politically possible, but that does not make it constitutionally permissible.

Other legal analysts and scholars who are examining this health care takeover legislation are raising additional constitutional objections. Professor Richard Epstein of the University of Chicago School of Law, for example, focuses on provisions that restrict insurance providers' ability to make their own risk-adjusted decisions about coverage and premiums. He argues these restrictions amount to a taking of private property without just compensation and in violation of the fifth amendment.

Others have observed that the legislation requires States to establish health benefit exchanges. It does not ask, cajole, encourage, or even bribe them. It simply orders State legislatures to pass legislation creating these health benefit exchanges and says if States do not do so, the Secretary of Health and Human Services will establish the exchanges for them. How thoughtful.

But as the Supreme Court said in FERC v. Mississippi in 1982:

> This Court never has sanctioned explicitly a federal command to the States to promulgate and enforce laws and regulations.

The Supreme Court reaffirmed a decade later in New York v. United States that ''the Framers explicitly chose a Constitution that confers upon Congress the power to regulate individuals, not States.''

In that case, the Court struck down Federal legislation that would press State officials into administering a Federal program.

More recently, in Printz v. United States, the Supreme Court stated:

> We have held, however, that State legislatures are not subject to Federal direction.

Yet this legislation does what these cases said Congress may not do. It commands States to pass laws, it regulates States in their capacity as States, and it attempts to make States subject to Federal direction.

Let me return to the principles with which I began. Liberty requires limits on government power. Those limits come primarily from a written Constitution which delegates enumerated powers to Congress. We must be able to identify at least one of those enumerated powers to justify legislation, and those powers should not mean whatever we, in our delightful wisdom, want them to mean.

Those principles lead me to conclude that Congress does not have the authority to require that individuals purchase health insurance, and that Congress cannot tax certain health insurance plans in some States but not in others.

These, and the others I have mentioned, are only some of the constitutional issues raised by this legislation. Any of these, and others I have not mentioned, could well be the basis for future litigation challenging this legislation should it become law.

Writing for the Supreme Court in 1991, Justice Sandra Day O'Connor reminded us:

> The Constitution created a Federal Government of limited powers.

America's Founders, she wrote, limited Federal Government power to ''protect our fundamental liberties.''

Here is the way Justice O'Connor put it, writing for the Supreme Court in New York v. United States in 1992:

> But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location, as an expedient solution to the crisis of the day.

That is a pretty remarkable statement. I could not have said it better myself. Those are either principles we must obey or cliches we may ignore.

If the Constitution means anything anymore, if it does what it was created to do by not only empowering but, more importantly, limiting government power, then now is the time to stand on principle rather than to slip on politics.

I yield the floor.

EXHIBIT 1

OCTOBER 25, 2009.

Hon. ORRIN G. HATCH,
U.S. Senator.

DEAR SENATOR HATCH: We support reducing the cost of health insurance and expanding access to quality, affordable prevention, wellness and health care services for all Americans. Despite our support for health care reform that empowers consumers, we have serious concerns about the constitutionality of the individual mandate requirement being proposed by Congress.

At least one scholar has argued that the individual mandate requirement is constitutional because Congress has unlimited authority under the Commerce Clause to regulate the economic activity of individual American citizens no matter how infinitesimal.

We do not agree with that position. In Philadelphia, the Framers established a federal government of limited powers. If Congress has unlimited power under the Commerce Clause to regulate the economic activity of citizens, then the Constitution is no longer (and never was) ''a promise . . . that there is a realm of personal liberty which the government may not enter.''

We believe that this promise still exists and is not a mirage. The Supreme Court said so, at least as recently as 2003.

It has also been argued that the individual mandate is constitutional because citizens have ''no fundamental right to be uninsured'' or ''to decline insurance.'' These are strawman characterizations intended to distract attention from the real constitutional question: Does Congress have the power to mandate citizens buy a specific good or service or be subjected to a financial penalty for not doing so?

Our reading of the Constitution and Supreme Court precedent could not identify any reasonable basis, expressed or implied, for granting Congress the broad, sweeping and unprecedented power that is represented by the individual mandate requirement. In fact, we could not find any court decision, state or federal, that said or implied that the Constitution gave Congress the power to mandate citizens buy a particular good or service or be subject to a financial penalty levied by the government for not doing so.

There are cases that say Congress can tell consumers what products to buy if they choose to buy, but no cases that say Congress can mandate that a citizen must buy a particular good or service or be fined for not doing so.

The individual mandate requirement directly burdens the fundamental meaning of being an American citizen as embodied in the Ninth Amendment reaching back through the Declaration of Independence to the Magna Carta and its expansion coming forward from the 3/5ths Clause of Article I of the Constitution and the Court's Dred Scott decision to the Thirteenth, Fourteenth, Fifteenth, Nineteenth, Twenty-Fourth and Twenty-Sixth Amendments as well as through Supreme Court decisions related to these amendments, legislation adopted pursuant to them, the Bill of Rights and its penumbra.

The Supreme Court has ruled that freedom of speech, expression and association are constitutionally protected. Our right to freely move around the country is also constitutionally protected. Congress can regulate the size of political donations but has no authority to tell a citizen which political candidate or party they can lawfully contribute to.

Like political donations, how a citizen legally spends their money in the market place is clearly a form of expression and association that requires strict scrutiny, or heightened, protection.

Calling the individual mandate a tax raises another constitutional concern. Under the mandate, American citizens are essentially subject to a financial penalty simply for being a citizen of the United States residing in a state of the Union. It is essentially an existence fee, a fee for existing.

Under the Fourteenth Amendment, the definition of citizenship does not include any requirement that Americans pay a ''tax'' simply because we are citizens. In fact, the Twenty-Fourth Amendment and related Supreme Court decisions expressly prohibit financially burdening the rights of citizens to prevent them from exercising a right of citizenship. Citizens have a liberty interest in deciding when to buy a good or service and which to buy form the legally available options.

The Supreme Court has said, ''Had those who drew and ratified the Due Process Clauses of the Fifth Amendment or the Fourteenth Amendment known the components of liberty in its manifold possibilities, they might have been more specific. They did not presume to have this insight. They knew times can blind us to certain truths and . . . laws once thought necessary and proper in fact serve only to oppress. As the Constitution endures, persons in every generation can invoke its principles in their own search for greater freedom.''

We believe that reducing the cost of health care insurance and expanding coverage can be achieved without opening the constitutional Pandora's Box of the individual mandate requirement.

Sincerely,

CARROLL G. ROBINSON, Esq.
MICHAEL O. ADAMS, PhD.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I am delighted to follow my colleague from Utah. I am pleased he has raised these constitutional issues, which I think are significant to this bill. The idea that we could have a constitutional mandate to buy health insurance, to me, is highly questionable under our rights under the role of the Federal Government and under the Constitution. Senator HATCH has been on the Judiciary Committee for many years and he understands these issues very well.

We are now on our sixth iteration of the health care reform bill. This one talks about expanding Medicare, basically as one of the key components of solving the problem. Here is a quote from the Mayo Clinic I found, and others have also been cited. I found this interesting, succinct, and accurate:

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. It is also clear that an expansion of the price control of the Medicare payment system will not control overall Medicare spending or curb costs. This scenario follows the typical pattern for price control, reduced access, compromised quality, and increasing costs anyway. We need to address these problems, not perpetuate them through health reform legislation.

That was the Mayo Clinic. It is clearly not the way to go to solve the crisis or the problems. It probably hastens the day Medicare goes bankrupt, which is set to happen in 2017, 7 years away.

I want to talk about the possibility that this health care bill puts this very early piece of economic recovery that we are having at risk. The latest reports on unemployment provide some hope that our battered economy may be showing some tentative signs of economic recovery, as the job loss continues to slow. Most of this is based off of monetary policy. We are seeing some of this taking place.

Consumer confidence is still low. Unemployment hovers at 10 percent, and over 7 million jobs were lost since the beginning of the recession.

It should be clear that any potential recovery is incredibly fragile. That being the case, Congress and the administration should focus like a laser beam on policies that encourage economic growth and put Americans back to work. That seems to be obvious.

Instead, though, the administration and the Democratic-controlled Congress have taken up crucial months with a proposed revamping of our entire health care system that will cost nearly $2.5 trillion over the next 10 years, to be paid for by new taxes and employer mandates, and it will impose a grave risk to a sustained rebound of our Nation's economy. This hurts our economic recovery.

Not only that, but the Democratic health care bill includes some positively perverse incentives that would discourage hiring, work, saving, and even marriage. Again, it would discourage hiring, work, savings, and marriage. Higher taxes, more employer mandates, and disincentives to job creation, productivity, and family formation are hardly the prescription for the growth our economy so desperately needs right now.

Both the House and the Senate bills would, for instance, increase the already existing penalty on work faced by many low-income families who receive tax and in-kind benefits from government welfare programs. We already heard this. Health insurance subsidies in the legislation for individuals and families in poverty would tack on an additional 12 to 20 percent to marginal tax rates, which already approach 40 to 50 percent for families receiving a variety of benefits for those with low incomes. This would result in marginal tax rates of 50 to 60 percent for most affected families.

If working more hours or obtaining better paying jobs results in more than half of those additional earnings being taken away as a result of taxes or a reduction in benefits—if you are a low-income individual, you are working more, you are getting more money coming in, but your benefits from the government are reduced. So if you are taking 50 to 60 percent away in a reduction of benefits or in taxes, the incentive to work harder or to invest in an education is greatly reduced. That is obvious on its face. Yet it is in this bill.

This is not the only work disincentive in the bill. It is common for teenagers and college students to obtain jobs so they can have some spending money on their own or to help with their educational expenses. The Senate bill penalizes the families of these younger workers by including their wages in benefit eligibility calculations. For many low-to-moderate income families, the inclusion of their wages could mean a significant increase in their cost of health insurance or even in them losing thousands of dollars of health insurance subsidies altogether. That is in the bill.

And more harmful to the economy, potentially, are the incentives directed at employers. Both the House and Senate bills include temporary subsidies to small businesses to encourage them to offer employer-sponsored health insurance. As the number of employees increase or as salaries increase, the amount of the credit provided to the business decreases. The structure of this subsidy not only discourages employers from hiring new employees, but it also discourages them from increasing employees' salaries. We don't want those sorts of disincentives in any bill.

Ironically, the incentives in the bill would even work to encourage employers to drop health insurance coverage for individual employees or eliminate insurance coverage altogether. The Senate bill would cap employee contributions to insurance premiums at 9.8 percent of their income. If an employer

offered a policy that required employees to pay more than this, the employee would be eligible to purchase insurance through the new ''health care exchanges.'' The employer would have to pay a fine. Since, in many cases, that fine is considerably less than the additional insurance costs the employer would incur if they retained coverage, many businesses concerned about the bottom line would be enticed by the bill to stop providing any health insurance coverage. So they are actually enticed here to drop health insurance coverage—another thing we don't want to see happen.

Furthermore, employers who offer flexible spending accounts or FSAs will be encouraged to stop providing these tax-free medical spending accounts for their employees. Under the Senate Democrats' bill, FSA contributions will be included in the total cost of employees' health insurance benefits for the purpose of calculating the proposed tax on high-cost health plans—the so-called Cadillac health care plans. Adding an FSA contribution could push the total cost of health benefits above the high-cost threshold for many workers, which will result in the employer being liable for a portion of the 40 percent high-cost plan's tax. As more and more plans become subject to the high-cost plan's tax, it will be in the employer's best interest to eliminate FSA offerings altogether. That is another disincentive we don't want to see happening.

The proposed legislation would also create new marriage penalties across the income spectrum. We have been working for some years to do away with the marriage penalty. Marriage is a good and solid institution that helps so much in this Nation. Yet it puts in a marriage penalty, penalizes people for getting married; it is built into this legislation. These penalties can be so large that, in some cases, couples would have to forgo marriage in order to avoid thousands of dollars in new taxes. The penalties are significant. Low- and moderate-income families often have limited savings as well. Given the already significant marriage penalties in low-income benefit programs, it seems ironic that the government would create yet another program that penalizes low-income individuals for getting married.

Currently, if they are on public assistance and they get married, their combined incomes often move a couple out of the support they receive for their families, whether it is health support, housing, or food support. By getting married, they often lose their benefits. Instead of taking them away, we ought to be helping them form solid families. That sort of disincentive is built into this health insurance plan as well, where you actually put in disincentives for low-income couples to get married. In other words, to be able to get the health insurance subsidy, they may have to forgo marriage. That is not the sort of incentive we want in the system and in the bill. We are trying to take it away in the welfare programs, but to add another piece to low and moderate-income couples is the wrong way for us to go.

That the Democratic health care legislation would set the United States on a path to a single-payer government-run health insurance system of the sort found in Europe and Canada is bad enough, but even more troubling is the fact that these proposals would create a series of perverse incentives ultimately harmful to workers, businesses, and the entire economy. The Senate must reject this poorly conceived, ruinously expensive scheme and get back to the business of helping our economy recover.

I have talked to many people across the United States and particularly in Kansas, many people who are deeply concerned about this economy and the perverse things coming out of Washington. While they might start considering investing in their small business, putting some income or something out to be able to grow and create jobs, people are holding back and saying: I don't know how many more taxes you will put on us or what the health insurance plan will look like. I don't know what cap and trade will do on raising energy costs.

They are holding back. These perverse economic signals, and the discussion of them in Washington, is perversely affecting the economy. It is hurting the economic recovery. If you put these pieces into place statutorily, you are hurting savings, hurting hiring, hurting marriage formation, and you will further hurt an already very tentative recovery from taking place.

This is a bad medicine for the economy. The idea that you would expand Medicare to take care of that is a terrible idea. You will be hurting a program that already is not financially solvent in the long term and is looking at something like $30 trillion of unfunded obligations already on its books. That alone, if you expand it back to age 55, plus the provider community—the American Medical Association and the American Hospital Association are opposed to this expansion of Medicare. They don't get full reimbursement of costs right now. With the talk about bringing it back to age 55, you will be sweeping a large number of people into Medicare, so you are sweeping in a lot of people who are already in private insurance plans. When they are pulled out of private insurance which pays at the full rate to the provider community, you are taking those resources away from the provider community, from doctors and hospitals. That is why you are seeing the American Medical Association and the American Hospital Association come out against this proposal on Medicare expansion. How on Earth would it ever be paid for, when the program is already not on a stable financial track?

The Federation of American Hospitals stated this:

> The FAH is strongly opposed to this proposal. A Medicare buy-in would involve Medicare rates, would be controlled by CMS, and would crowd out older workers with private coverage and may choose early retirement as a result. Such a policy will further negatively impact hospitals.

In my rural State, in particular, it would have a huge negative impact on a number of the hospitals in my State.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, is there a unanimous consent order of business?

The PRESIDING OFFICER. There is not.

Mr. DURBIN. Mr. President, I rise to speak as in morning business.

I would like to say at the outset I respect very much my colleague from the State of Kansas. He and I have worked on many issues together. In fact, we traveled together to Africa, a memorable trip for both of us, I am sure, visiting the Democratic Republic of Congo, Rwanda, and meeting a lot of people in desperate straits. I thank him for that.

I know he is now preparing for another public career in the State of Kansas, with the blessing of the Kansas voters. But in the meantime, he continues to be a very important, vital voice in the Senate. I thank him for that as well.

We do disagree on health care reform. I know he has had a chance to explain his point of view. I will say I disagree with many of his conclusions about what we are about, what we are trying to accomplish.

This is the bill that is before us when we return to the health care reform debate. It is 2,074 pages long. It is the product of 1 year's work by two major committees in the Senate. The House of Representatives spent a similar period of time in three different committees working on it to come up with their work product, which they passed just a few weeks ago.

This is historic because we have been promising this and threatening this and talking about this for decades. It was Theodore Roosevelt who first raised the question about whether America could accept the challenge of providing health care for every citizen. That was over 100 years ago. Then, of course, Harry Truman, who, in a more modern era, issued the same challenge. He was confronted by his critics who said: He is talking about socializing medicine. Must be socialism that Harry Truman is proposing. The idea died.

Then, again, Lyndon Johnson raised it in the early 1960s. He was a master of the Senate, as he has been characterized in a book that has been written about him. He believed he had the power to make this happen to deal with the health care system across the board in America. It turned out he made a significant contribution with the enactment of Medicare and Medicaid but could not reach the goal of universal health care or comprehensive health care reform.

This President, President Obama, came to us and issued the same challenge. He said we have reached a point of no return. The current health care system in America is unsustainable, it is unaffordable, and the cost of health care goes up dramatically. Ten years ago, a family of four paid an average of $6,000 a year, $500 a month for health care insurance. Now that is up to twice that amount, $12,000 average for a family of four, $1,000 a month. In 8 years, with projected increases in costs, we expect that the monthly premium for the family of four to go up to $2,000 a month, $24,000 a year. We know that represents 40 percent of earnings for many people. That is absolutely unsustainable.

What we have tried to do, first and foremost, is address affordability. How can we make health insurance protection more affordable for more families? How can we start lessening the annual increase in premiums and actually help people by substantially cutting the cost of premiums for many families? It is a big challenge, and we have, I think, risen to the challenge with this bill.

The other side of the aisle has ideas, they have amendments, they have speeches, they have charts, but they do not have a comprehensive health care reform bill. They do not have a bill that has been sent over to the Congressional Budget Office, carefully read, and evaluated. It took weeks to do it. They do not have a bill that came back from the Congressional Budget Office, considered to be the neutral observer of action on Capitol Hill. They do not have a bill that came back from the CBO that has been characterized as actually reducing the deficit.

This bill, according to the Congressional Budget Office, will reduce America's deficit over the next 10 years by $130 billion and over the following 10 years another $650 billion. It is not just dealing with health care reform; it is dealing with the costs of health care to our government and reducing our expenditures by significant amounts. It is the largest deficit-reduction bill ever considered on the floor of the Senate.

Although the Republicans have many ideas, they do not have anything that matches this bill in terms of deficit reduction or bringing down the cost of health care. They have not produced a bill which will extend the reach of health insurance coverage to 94 percent of our people in this country, which this bill does.

For the first time in the history of the United States of America, 94 percent of our American citizens will have peace of mind knowing they have health insurance. Today, 50 million do not. This bill will take 30 million off the uninsured rolls and put them in insurance plans that can protect their families, and it will help them pay for the premiums. If people are making less than 400 percent of poverty—which in layman's terms is about $80,000 a year in income. If your family makes $80,000 or less, we provide in this bill that we will help you pay for your premiums. The lower your income, the more we will help pay.

If you are making, for example, as an individual, less than $14,000 a year, you will not pay for your health care. It will be covered by Medicaid, the program that is now nationwide, and you will not have to pay a premium. Then as you make more money, you will pay a little bit of a premium with help from this bill.

The Republicans have not produced a plan of any kind that deals with helping families of limited means, modest means, pay for their health insurance premiums. We have. The Congressional Budget Office has scored it. One of the major provisions in this bill—and one I think most people will identify with quickly—is the fact that health insurance reform is included too. There is a Patients' Bill of Rights in this bill. It basically says we should bring an end to the discriminatory practices of health insurance companies against American citizens. We know what we are talking about.

Friends of mine, a family I am closer to than any other family in Springfield, IL, has a son fighting cancer. He is a young man in his forties. He has young children in high school. He was diagnosed with melanoma just a few years ago. His oncologist has worked with him with chemotherapy and radiation and with the kind of treatment and drugs and surgeries he needed. As a result of it, he has gone through some tough surgeries and tough treatment. His oncologist said at one point: We have a drug we believe will help you. He gave him the drug, and the drug, in fact, arrested the development of his cancer.

Shortly after the drug was prescribed and administered, his health insurance company that he paid into for years came back and said: We will not cover that drug. The drug costs $12,000 a month. It is impossible for him, as the coach of a baseball team at one of our universities, to come up with that kind of money. His family borrowed money to pay for one of the treatments, and now they are suing the insurance company in the hopes that they can get coverage.

After all those years paying in, when they finally needed that coverage, they turned him down. I hope he wins that lawsuit. This is a very profitable insurance company. It is a company that should be paying, but they are not. That is one example of thousands we could talk about.

The purpose of this bill is to make sure a friend of mine, his family, and other families just like his have a fighting chance against these insurance companies. We say in this bill we are going to provide a way for protection for people with a preexisting condition; that if you have a history of high cholesterol or high blood pressure, if you have some cancer in your family, it is not going to disqualify you. You are still going to be eligible for health insurance, a policy you can afford.

We also say, when it comes to your children—you know how it is today, you learn the hard way—when your kids who are on the family plan reach the age of 24, they are off. We extend that to age 26, which I think is a little more peace of mind, particularly for students graduating from college looking for jobs these days. It is not easy. We want to make sure they are covered with health insurance while they are paying off their student loans and building their career. That is in this bill.

There is not a bill from the Republican side of the aisle that deals with the Patients' Bill of Rights. In fact, it is a rare Senator on the other side of the aisle who even stands and is critical of health insurance companies in the way they are treating people in this country.

I do not know if my friends on the other side of the aisle get back home enough to meet with some of these families. Surely they do. They must receive mail that tells them about these stories we have all heard about. You would think they would be endorsing our approach in this bill. Instead, they are critical of it from start to finish.

They talk a lot about taxes. I want you to know, under this bill, if you have a small business with 25 or fewer employees, we actually provide tax breaks to help you provide insurance for your employees. There are a lot of businesses, mom-and-pop businesses, for example, that cannot afford health insurance that will have a chance now because of tax breaks here.

Then, when it comes to paying for premiums, I mentioned earlier, if you make $80,000 or less, we provide tax breaks in helping you pay for it. The cost of it in tax breaks is $440 billion over 10 years. It is a huge amount of money we are providing to American citizens to give them a chance to pay for their health insurance premiums. All we hear from the other side is: Oh, this bill is going to raise taxes. It does raise some. It raises taxes on health insurance companies for what we call Cadillac health care policies.

We can debate for a long time whether that level of policy, $25,000, is a reasonable level or should be something different. But the fact is, it is a tax on the health insurance company. It will likely result in fewer policies that are that grand and that expansive being issued.

I think this is a bill that moves in the right direction. It is a bill that makes insurance more affordable. It is a bill that does not increase the deficit, it reduces it. It is a bill that gives people a fighting chance against health insurance companies that discriminate against their customers. It is a bill that extends the coverage of health insurance of 94 percent of Americans. It is a bill that looks at putting Medicare on sound footing. It adds 5 years of solvency to Medicare—5 years. There has not been a bill produced on the other side of the aisle that even adds 1 year,

that I am aware of. It adds 5 more years of solvency. That is the reason why this bill has been supported by the American Association of Retired Persons. We have support of medical professionals, senior organizations, and consumer groups all across America. They know, as we do, we cannot wait any longer.

I also wish to make the point that the Senate bill offers significant savings for seniors. The CMS Actuary projects a net $469 billion in Medicare and Medicaid savings over 10 years, slightly more than the Congressional Budget Office. It extends the life of the Medicare trust fund, according to the Office of the Actuary, by 9 years. That is longer than anyone has projected in previous forecasts, but it is a significant increase, almost doubling the life of the Medicare trust fund over what it currently would be.

It reduces premiums by $12.50 a month by the year 2019 or $300 per couple per year. Slowing Medicare growth will lower health care costs for seniors as well as younger Americans. Not only will there be a premium savings, but coinsurance will fall as well.

The Senate bill slows the growth of health care costs. The Actuary report we have, for example, says, '' . . . Reductions in Medicare payment updates for providers, the actions of the Independent Medicare Advisory Board, and the excise tax on high-cost employer-sponsored health insurance would have a significant downward impact on future health care cost growth rates.''

The bend in the health care cost curve is evident. Health care costs under the Senate bill begin to decline as cost savings begin to kick in.

I have not mentioned this bill focuses on prevention and wellness too. If there is one thing we need, it is to encourage people to take care of themselves and to get a helping hand for the tests they need to stay healthy and to monitor their conditions. This preventive care and wellness, though we have not been credited by the Congressional Budget Office, is an important element of this bill.

I think there is one thing on which we should all agree. The cost of health care, particularly for small businesses, is very difficult. On the Senate floor, both Democrats and my friends on the other side of the aisle have recognized small businesses are struggling to pay for health insurance. But there is a real difference. We have offered a solution, one that is comprehensive and one that has been scored and carefully analyzed by the Congressional Budget Office.

Unfortunately, that has not happened on the other side. Their approach is basically to criticize what we have proposed but to offer no alternative. If they are happy with the current system, I understand that. If they will concede that it is hard to produce a bill like this, I would understand that. But merely to criticize this without alternative, a comprehensive alternative that has been carefully analyzed, I don't think is a responsible approach to the serious problem that we face today.

There are real-life stories of people who have contacted me. One of them I will tell you about involves a small business. Right now we know that one sick employee of a small business can drive the cost of health care for the whole company to limits where they just can't afford it. My friends, Martha and Harry Burrows, whom I have met, are small business owners in Chicago, and they have to wrestle with this problem and try to run a successful business at the same time. When they opened their toy store, Timeless Toys, 16 years ago, they promised to provide health insurance to their full-time employees. Martha Burrows said:

> Since we were covered, we wanted to offer the same benefit to our employees.

But as their health care premiums have skyrocketed with leaps of more than 20 percent at a time, the commitment has taken its toll on their business. Providing health insurance to their full-time staff of seven meant cuts not only to profits but also to the wages of their employees. In general, the older employees faced even higher costs. We shouldn't put our Nation's employers in a position where the health costs of an older worker can make such a huge difference.

Marcia says:

> I don't like making decisions that way. I want to base hiring decisions on the quality of the person.

The legislation on the floor, incidentally, deals with the rating of premium costs for senior citizens, for example, and makes a fairer rating system. Currently, health insurance companies in America are exempt from the antitrust laws. Under a bill known as McCarran-Ferguson, passed in the 1940s, they are exempt, along with organized baseball, which means the insurance companies—health insurance companies and others—can literally sit down in a room and conspire, collude, agree on prices they are going to charge. If any other companies that were supposed to be competing did that in America they would be sued but not the insurance companies. So they can set premiums and agree on what the premiums will be, and they can divide up the market for the sale of their products, sending some companies to one town and some to another, making sure they do not compete against one another.

That is the reality of health insurance today. What we provide in this bill is protection against the ratings which discriminate against people because they are elderly or because they are women. We put limits to the rating differences that will be allowed in health insurance policies. There is no bill I know of from the Republican side that even considers or addresses that problem.

Mr. President, one of the issues that I have tried to focus on in the midst of this recession is our foreclosure crisis. Back in December of 2006, when the housing markets were humming along and the bankers and brokers were raking in money, the Center for Responsible Lending published a report called ''Losing Ground.'' That report, in December of 2006, estimated that nearly 2 million homes would be lost to foreclosure in the coming years due largely to shoddy subprime mortgages.

Here is what the Mortgage Bankers Association told the Washington Post when they heard of this study. It was authored by the Center for Responsible Lending.

> The report is 'wildly pessimistic' because most homeowners have prime loans and are not at financial risk.

That is what a senior economist at the Mortgage Bankers Association said in December of 2006. He went on to say:

> The subprime market is a small part of the overall market. Lending industry officials have said that regulatory action could injure the subprime market.

When he speaks of regulatory action, he means regulating these subprime markets.

On the floor of the Senate, I was involved in a debate with a Senator from Texas named Phil Gramm. I offered an amendment to a bankruptcy bill which Senator GRASSLEY and I worked on which said: If you are guilty of predatory lending, you will be precluded in bankruptcy from pursuing your claim. That was debated on the Senate floor, and debating on the other side against my amendment was Senator Phil Gramm of Texas, who said on the floor of the Senate:

> If the Durbin amendment passes, it will destroy the subprime mortgage market.

Well, my amendment failed by one vote, and the subprime mortgage market continued until it collapsed just a couple of years ago. I wish I had had another vote for my amendment.

At the time this debate took place in December of 2006, about 25 percent of home loans were subprime. So the mortgage bankers, unfortunately, misled the public about the state of the market at the time to wave away warnings about any crisis that might be following, and we all know what that has meant to this country.

I go back to that episode now because 3 years later, in 2009, we have had more than 2 million foreclosures, something the Mortgage Bankers Association said wouldn't happen. In fact, the Mortgage Bankers Association has recently announced that in the third quarter of this year, nearly one in seven families paying mortgages in this country were either behind on their payments or already in foreclosure—one out of seven people holding mortgages today. It is hard to imagine. That is the highest it has ever been.

The statement from the Mortgage Bankers Association said:

> Despite the recession ending in mid-summer, the decline in mortgage performance continues.

Three years ago, the rosy scenario they painted has now morphed into a

much more serious situation which they cannot ignore. I have been talking about this foreclosure crisis since early in 2007. I stand here with some regret and say it is getting worse.

In Illinois, foreclosure filings in the six-county region around Chicago went up 67 percent in the last quarter. This isn't just a problem for the city of Chicago. New filings in Cook County, mainly suburban areas, were down 4.6 percent last quarter. The problem, unfortunately, has migrated to the suburbs. All of the so-called ''collar counties'' around Chicago have experienced massive increases in foreclosure activity. Kane County, a near-in county to the city of Chicago, saw foreclosure filings increase 97 percent in the last quarter over a comparable period last year.

I know the administration is working on this. The Home Affordable Modification Program is helping some families. I know Treasury has stepped up naming and shaming and hoping that it will provide more data for the public on which banks are actually trying. Some are—not much but some are. Many are not trying at all to renegotiate mortgages for people facing foreclosure. But no matter how much the Treasury Department leans on these bankers, the big banks that service most of these troubled mortgages have simply not stepped up to the plate.

Treasury reported yesterday that 3.3 million families are eligible for the Home Affordable Modification Program. Those are the families who are at least 2 months behind on their mortgages and in serious risk of being thrown out in the street. How many families, based on this 3.3 million families eligible for this program, have been able to get a bank to commit to a permanent loan modification that will keep them in their homes? There were 31,000 out of 3.3 million; less than one-tenth of 1 percent of the families in trouble have been able to work out a permanent solution with their bankers. That is disgraceful.

The big banks that created this mess continue to stand in the way of cleaning it up. They are making billions of dollars while foreclosing on millions of American families. Shaming the banks with speeches on the floor of the Senate isn't going to work. We have learned the hard way that many banks are beyond embarrassment. You can't embarrass bankers who take billions of taxpayer dollars to stay solvent and to overcome their bad banking policies, then turn around and pay millions out in bonuses to the officers of the same banks. You can't publicly shame bankers into doing something when they simply don't care.

But let's be clear. Congress hasn't done its part either. We have not done enough to make these banks help the American people who need some help. I will continue to come to the floor to remind my colleagues that we must address this crisis far more aggressively than we have, and I will continue to look for ways to help.

One last statistic. The Wall Street Journal ran a front-page story recently highlighting that one in four homeowners who are paying a mortgage today owes more on their mortgage than their house is worth. One in four homeowners is making house payments on a home that is now underwater. If you owe more than your house is worth and have no extra cash lying around, you are really vulnerable. If there is a sickness in your family, a health care emergency, a job loss, you could lose your home. If you are underwater, you are likely to stay there.

The 10.7 million families who find their mortgages are higher than the value of their homes are at serious risk of foreclosure. Over 400,000 of those families are at risk in my home State of Illinois. JPMorgan Chase estimates that home prices won't hit bottom until next year, so it is going to get worse before it gets better.

So do we stand idly by and watch this—watch people lose their life's savings and their homes, watch these boarded-up homes spring up across our neighborhoods, around towns large and small across America and shake our heads and say it is inevitable? We don't have to. What we have to do is lean on these banks legally, with new laws that put pressure on them to make a difference. Don't appeal to their better nature. We have tried that, and it didn't work. We have to use the law. We have to stand up for this economy and putting it back on its feet, and we have to make the point of saying to these bankers that they have to negotiate these mortgages.

We need to do our part in the Senate. As we focus on health care and jobs and the state of the economy, let's not lose sight of this foreclosure crisis that is devastating neighborhoods across the country. The economy will struggle to fully recover until more families are confident enough in their homes that they are willing to go out and go shopping again. We must do more.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I had a chance to listen to my good friend, the Senator from Illinois; his remarks about why the bill before the Senate is going to reduce costs and pay down on the national debt. Now, that is the Senator from Illinois. I am the Senator from Iowa. But I would like to not refer to my judgment about this bill right now. What I would like to refer to is the judgment outlined in a report that was issued today from the Chief Actuary of the Centers for Medicare & Medicaid Services in the Department of Health and Human Services, a professional person who calls it like it is. That is his responsibility.

Remember, I am quoting from a report that was just given today about this 2,074-page bill we have before us, and that my friend from Illinois was just speaking very favorably about. So I am going to talk about somebody in the executive branch of government, under the President of the United States, who says this about this reform bill—that it will cost more than the status quo. The Chief Actuary of the Centers for Medicare & Medicaid Services issued a report on Senator REID's bill which shows that health care costs would go up, not down, under his bill. The Chief Actuary warned that the Democrats' health care bill would increase health care costs, threaten access to care for seniors, and force people off their current coverage.

In other words, the administration's own Chief Actuary conclusively demonstrates that the Democrats' rhetoric does not match the reality of the bill. The cost curve would bend up, not down. National health expenditures would increase from 16 percent of GDP to 20.9 percent under the Reid bill. The Chief Actuary concluded that the Federal Government and the country would spend $234 billion more under the bill than without it. The Chief Actuary also says that the bill ''jeopardizes access to care for beneficiaries'' because of the bill's severe cuts in Medicare.

Quoting the Chief Actuary:

> Providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and . . . might end their participation in the program (possibly jeopardizing access to care for beneficiaries).

Then it speaks about the savings in the bill being unrealistic. The Actuary says that many of the Medicare cuts ''are unrelated to the providers' costs of furnishing services to beneficiaries.'' It is therefore ''doubtful'' that providers could reduce costs to keep up with the cuts.

Then the Chief Actuary speaks about new taxes costing consumers $11 billion per year. The new taxes in the Reid bill would increase drug and device prices and health insurance premiums for consumers. The Actuary estimates this would increase costs on consumers by $11 billion per year, beginning in 2011—that is 3 years before most benefits kick in.

Then the Actuary speaks about health care shortages, that these health care shortages are ''plausible and even probable,'' particularly for Medicare and Medicare beneficiaries. Because of the increased demand for health care, the Actuary says that access-to-care problems—again these words ''plausible'' and even ''probable'' under the Reid bill. The access problems will be the worst for seniors on Medicare and low-income people on Medicaid. The Actuary says ''providers might tend to accept more patients who have private insurance with relatively attractive payment rates and fewer Medicare and Medicaid patients, exacerbating existing access problems for the latter group.''

Premiums for the government-run plan would actually be higher than under private plans. Agreeing with the Congressional Budget Office, the Chief Actuary said that because the government plan would not encourage higher

value health care and it would attract sicker people, premiums for the government-run plan would be 4 percent higher than for the private insurers.

Then there is a point about employers dropping coverage. The Chief Actuary concluded that 17 million people will lose their employer-sponsored coverage. Many smaller employers would be ''inclined to terminate their existing coverage'' so their workers could qualify for ''heavily subsidized coverage'' through the exchange.

Then it speaks, lastly, about the long-term health care part of this bill called the CLASS Act. The CLASS Act stands for Community Living Assistance Services and Support, C-L-A-S-S.

The Chief Actuary has determined that the CLASS Act long-term care insurance program faces ''a significant risk of failure'' because the high costs will attract sicker people and lead to low participation. Even though premiums would be $240 a month, the policy would result in ''a net Federal cost in the long term.''

I think quoting the Chief Actuary is a very good way to bring attention to the shortcomings that, on this side of the aisle, we have tried to discuss about the 2,074-page bill. Members on this side of the aisle have shown that the Reid bill will bend the health spending curve the wrong way over the next year and that the Reid bill cuts Medicare by $½ trillion and jeopardizes seniors' access to care. So, again, quoting from the Health and Human Services Chief Actuary's analysis confirms the dangerous consequences of the 2,074-page Reid bill.

I would like to highlight some of the findings in a more encompassing way than I just did, quoting the Chief Actuary.

First, contrary to what Members on the other side of the aisle claim, the Chief Actuary's report confirms that the Reid bill bends the cost curve the wrong way. According to the HHS Chief Actuary, over the next 10 years—and this chart highlights it—''total national health expenditures under this bill would increase by an estimated total of $234 billion.'' And a good portion of the increase in national health expenditures would be caused by the so-called fees in this bill on medical devices and on prescription drugs and on health insurance premiums.

Here we have a chart where the Chief Actuary found that ''. . . fees would . . . be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums . . .'' This would result in ''. . . an associated increase of approximately $11 billion per year in overall national health expenditures.'' This refutes claims from the other side that the so-called fees won't be passed on to consumers. And this analysis clearly refutes claims from the other side that the Reid bill saves money.

Next, the Chief Actuary also confirms that the Reid bill jeopardizes beneficiary access to care. The Chief Actuary tallied up around $493 billion in net Medicare cuts, and he raised concerns in particular about two categories of these Medicare cuts.

First, the report warns about the permanent productivity adjustments to annual payment updates. These productivity adjustments ''automatically cut annual Medicare payment updates based on productivity measures for the entire economy,'' not just for that section of health care part of the economy.

The Chief Actuary confirms that these permanent cuts would threaten access to care. Referring to these cuts, he wrote that ''. . . the estimated savings . . . may be unrealistic'' and ''. . . possibly jeopardizing access to care for beneficiaries.''

''It is doubtful that many could improve their own productivity to the end achieved by the economy at large.'' This is a direct quote from the Chief Actuary's report. He goes on to say, ''We are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy.''

In other words, basically he is saying this: If you are going to make a judgment that you are going to cut health care costs and that productivity has to be measured by the entire economy, you can't take the entire economy and apply it to a small segment of the economy—health care—and expect it to be fair and expect that small segment of the economy to be as productive and equal the productivity of the entire U.S. economy.

You have to listen to these people who are professionals in these areas. The Chief Actuary is a professional. In fact, the Chief Actuary's conclusion is that it would be difficult for providers to even remain profitable over time, as Medicare payments fail to keep up with the cost of caring for beneficiaries.

Referring to this chart, ultimately, here is the Chief Actuary's conclusion: that providers who rely on Medicare might end their participation in Medicare, ''. . . possibly jeopardizing access to care for beneficiaries.'' That is right out of the Chief Actuary's report, is where that quote comes from.

He even has numbers to back up these statements. His office ran simulations of the effect of these drastic and permanent cuts. Here we have the quote. Based on the simulations, the Chief Actuary found that during the first 10 years, ''. . . 20 percent of Medicare Part A providers would become unprofitable . . . as a result of productivity adjustments.

This is going to be horrible on rural America where we already have difficult times recruiting doctors and keeping our hospitals open. As I said, it is difficult to keep up with these productivity adjustments by our providers. It is for this reason that the Actuary found that ''reductions in payment updates . . . based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis.'' That is right out of the report of the Actuary.

The second category of Medicare cuts the Chief Actuary raises concerns about would be imposed by the new independent Medicare advisory board created in this 2,074-page bill. This new body of unelected officials would have broad authority to make even further cuts in Medicare. These additional cuts in Medicare would be driven by arbitrary cost growth targets based on a blend of general economic growth and medical inflation. This board would have the authority to impose further automatic Medicare cuts, even absent any congressional action.

The Chief Actuary gives a reality check to this proposal. He shows how tall an order the Reid bill's target for health care cost growth actually is.

Again quoting the Actuary:

> Limiting cost growth to a level below medical price inflation would represent an exceedingly difficult challenge.

He points out in this analysis that Medicare cost growth was below this target in only 4 of the last 25 years. Just think—what this 2,074-page bill is trying to accomplish is something that has been accomplished in only 4 out of the last 25 years.

The Actuary also points out that the backroom deals that carved out certain types of providers would complicate this board's effort to cut Medicare. So, to this analysis:

> The necessary savings would have to be achieved primarily through changes affecting physician services, Medicare Advantage payments, and Part D.

So providers, such as hospitals, will escape from this board's cut at the expense of doctors, Medicare Advantage plans, and higher premiums imposed on beneficiaries for their Medicare drug coverage, Part D of Medicare. If we survey the Nation's seniors, I doubt very much they would say that raising their premiums for Medicare drug coverage is what they would call health care reform.

This board, which can cut reimbursements, is guaranteed to have to impose these additional Medicare cuts. In other words, they can do it.

According to the Chief Actuary's analysis of the Medicare cuts in the Reid bill, even though the Medicare cuts already in the Reid bill are ''quite substantial,'' they would—the savings ''would not be sufficient to meet the growth rate targets.'' This means the board will be required by law to impose even more Medicare cuts, in addition to the massive Medicare cuts already in the bill.

This bill imposes a $2½ trillion tab on Americans. It kills jobs with taxes and fees that go into effect 4 years before the reforms kick in.

It kills jobs with an employer mandate. It imposes $½ trillion in higher taxes on premiums, on medical devices, on prescription drugs and more. It jeopardizes access to care with massive

Medicare cuts. It imposes higher costs. It raises premiums. It bends the growth curve the wrong way; in other words, up instead of down. This is not what people have in mind when they think about health care reform.

There is another aspect to this bill that I wish to go over. I hope the third time is the charm. I hope this time the other side of the aisle will understand that the Reid bill increases taxes on middle-income families, individuals, and single parents. That is because contrary to the claims made by the other side of the aisle, the Reid bill clearly raises taxes on middle-income Americans. We have data, not from this Senator, but as I quoted previously the expertise of the Chief Actuary, I want to quote the expertise now of the Joint Committee on Taxation, professionals who are blind to politics, who judge things and call them like they see them. Yesterday I pointed out how the same Joint Committee on Taxation data led my Democratic friends to proclaim that the Reid bill provided a net tax cut to all Americans. We have this distribution chart I used previously to show that that net really is not net.

There is no question that the bill does provide a tax benefit to a group of Americans, a relatively small group. A much larger group, however, will see their taxes go up. Most, if not all in this group, will not benefit from the government subsidy for health insurance. That is part of this 2,074-page bill. As a result, the generous subsidy that is in that bill that is going to a small group of Americans cannot be used by this larger group to offset their increased tax liabilities. The other side, however, wants to spread the large tax benefit that is going to this small group of Americans to everybody; in other words, all Americans, even among those Americans who are not eligible to receive the subsidy, and then somehow claim that all Americans are receiving a tax cut. How can a person receive a tax cut if they are not receiving some type of tax benefit?

Yes, the data shows that some will receive a benefit, but the data also shows that the others will see a tax increase. I have highlighted in yellow these various figures, individuals and families who will see a tax increase. In general, these individuals and families are not receiving the subsidy for health insurance. This means they have no government benefit to offset their new tax liability. The most important point I want to make—for the third time—is that these tax increases fall on individuals making more than $50,000 and families making more than $75,000. Again, I highlighted this group on the Joint Committee on Taxation chart.

The Joint Committee distributed in this chart three separate tax provisions: the high-cost plan tax, the medical expense deduction limitation, and the Medicare payroll tax. Among these tax provisions, the high-cost plan tax seems to be garnering the most attention and also tremendous opposition. I don't have to explain who the opponents of this tax increase are. Everybody knows. In fact, yesterday I had representatives of the Iowa Education Association, the teachers of Iowa, saying they are against that high plan tax because it is going to hurt Iowa teachers. So if this provision, the high-cost plan tax, were to drop out of the Reid bill for one reason or another—and this bill is still being written in secret or at least changes in this 2,074-page bill are being written in secret so who knows what is going to happen to this highly controversial thing—if it is taken out, some Members may feel they have successfully shielded the middle class from a tax increase. Unfortunately, for those Members who may be hopeful of this, lesser known tax provisions that are likely to stay in the changes that come through the Democratic health care reform product would still raise taxes on the middle class.

Again, don't take my word for it. The Joint Committee on Taxation tells us so. Specifically, that committee sent a letter to Senator CRAPO stating that tax provisions such as the cap on flexible savings accounts, the elimination of tax reimbursements for over-the-counter medicines and, most importantly, the individual mandate excise tax penalty will increase taxes on people making less than $250,000. That happens to be middle-class individual, middle-class families, and middle-class single parents.

I ask unanimous consent to have printed in the RECORD that letter.

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

CONGRESS OF THE UNITED STATES,
JOINT COMMITTEE ON TAXATION,
Washington, DC, December 9, 2009.

Hon. MIKE CRAPO,
U.S. Senate,
Washington, DC.

DEAR SENATOR CRAPO: This letter is in response to your request of December 8, 2009, for information regarding the ''Patient Protection and Affordable Care Act,'' as introduced by Senator Reid. In particular, you requested that we provide you with information on the provisions in the bill that would increase tax liability for taxpayers with adjusted gross income (''AGI'') under $200,000 ($250,000 in the case of a joint return).

In previous correspondence with you, we provided a distributional analysis of the bill. In estimating the distributional effects of the bill, we distributed items that have economic incidence on individuals, including some items that do not have statutory incidence. We are enclosing a copy of that distributional analysis for reference. Included in the distribution table are the following items that would have statutory incidence as well as economic incidence on individuals and are likely to increase tax liabilities for some taxpayers with AGI below $200,000 ($250,000 in the case of a joint return):

1. Raise the 7.5 percent AGI floor on medical expenses deduction to 10 percent; and
2. Additional 0.5 percent hospital insurance tax on wages in excess of $200,000 ($250,000 joint).

You asked us to enumerate items that we have not previously distributed and that we believe could affect the tax liability of taxpayers with AGI below $200,000 ($250,000 in the case of a joint return). Below is a list of the provisions that we have not previously distributed and that have statutory incidence on individuals, with some of those individuals likely to have income below your threshold:

1. Conform definition of medical expenses for health savings accounts, Archer MSAs, health flexible spending arrangements, and health reimbursement arrangements;
2. Increase the penalty for nonqualified health savings account distributions to 20 percent;
3. Limit health flexible spending arrangements in cafeteria plans to $2,500;
4. Impose a five-percent excise tax on cosmetic surgery and similar procedures; and
5. Impose an individual mandate penalty.

I hope this information is helpful to you. If we can be of further assistance in this matter, please let me know.

Sincerely,

THOMAS A. BARTHOLD.

Enclosure.

#D-09-26
November 19 2009

DISTRIBUTIONAL EFFECTS OF A PROPOSAL TO IMPOSE A 40 PERCENT EXCISE TAX ON HEALTH COVERAGE IN EXCESS OF $8,500/$23,000 ($9,850/$26,000 FOR RETIRED AND HIGH RISK) INDEXED TO THE CPI-U PLUS ONE PERCENTAGE POINT; PROVIDE EXCHANGE PLAN CREDITS AND SUBSIDIES TO CERTAIN LOW-INCOME TAXPAYERS; INCREASE HI TAX ON EARNINGS IN EXCESS OF $200,000 ($250,000 JOINT FILERS); AND INCREASE THE AGI FLOOR FOR MEDICAL EXPENSE DEDUCTIONS TO TEN PERCENT(1)

Calendar Year 2017

INCOME CATEGORY (2)	CHANGE IN FEDERAL TAXES (3)		FEDERAL TAXES (3) UNDER PRESENT LAW		FEDERAL TAXES (3) UNDER PROPOSAL		Average Tax Rate (4)	
							Present Law	Proposal
	Millions	Percent	Billions	Percent	Billions	Percent	Percent	Percent
Less than $10,000	-$60	-0.6%	$10	0.3%	$10	0.3%	7.3%	7.2%
$10,000 to $20,000	-$6,154	-32.3%	$19	0.6%	$13	0.4%	4.8%	3.3%
$20,000 to $30,000	-$19,168	-36.7%	$52	1.7%	$33	1.1%	10.4%	6.6%
$30,000 to $40,000	-$18,744	-21.3%	$88	2.8%	$69	2.3%	13.9%	10.9%
$40,000 to $50,000	-$12,573	-11.3%	$111	3.6%	$98	3.2%	14.5%	12.9%
$50,000 to $75,000	-$12,007	-3.7%	$325	10.5%	$313	10.2%	16.2%	15.6%
$75,000 to $100,000	$2,292	0.7%	$346	11.1%	$349	11.4%	18.0%	18.1%
$100,000 to $200,000	$14,387	1.6%	$887	28.5%	$902	29.4%	22.6%	23.0%
$200,000 to $500,000	$6,187	1.2%	$535	17.2%	$541	17.6%	27.7%	28.0%
$500,000 to $1,000,000	$2,360	1.2%	$205	6.6%	$207	6.7%	29.9%	30.3%
$1,000,000 and over	$3,454	0.7%	$531	17.1%	$534	17.4%	29.8%	30.0%
Total, All Taxpayers	**-$40,024**	**-1.3%**	**$3,109**	**100.0%**	**$3,069**	**100.0%**	**21.2%**	**20.9%**

Source: Joint Committee on Taxation
Detail may not add to total due to rounding.

(1) The proposal would impose a 40% excise tax at the insurer level on health coverage in excess of $8,500 for single plans and $23,000 for family plans. For retired individuals age 55 and over or those covered by a plan for high risk industries, the 40% excise tax would apply on health coverage in excess of $9,850 for single plans and $26,000 for family plans. Amounts would be indexed for inflation by the CPI-U plus one percentage point in years after 2013. The excise tax is nondeductible. The proposal would provide transition relief for the high 17 states. Under the proposal, refundable tax credits would be provided to taxpayers who enroll in exchange plans with income between 100 percent and 400 percent of FPL. The proposal provides for outlays in the form of cost-sharing subsidies for out-of-pocket medical expenses for exchange participants between 100% and 200% of FPL. The proposal increases the AGI threshold for the deduction of medical expenses from 7.5% to 10%, except age 65 and older. The proposal would increase the hospital insurance ("HI") tax by 0.5 percentage points on earning in excess of $200,000 ($250,000 for married couples filing jointly. The analysis includes the revenue effects of changes in excludable compensation due to the effects of the broader reform on employer sponsored coverage.

(2) The income concept used to place tax returns into income categories is adjusted gross income (AGI) plus: [1] tax-exempt interest, [2] employer contributions for health plans and life insurance, [3] employer share of FICA tax, [4] worker's compensation, [5] nontaxable Social Security benefits, [6] insurance value of Medicare benefits, [7] alternative minimum tax preference items, and [8] excluded income of U.S. citizens living abroad. Categories are measured at 2009 levels.

(3) Federal taxes are equal to individual income tax (including the outlay portion of refundable credits), employment tax (attributed to employees), and excise taxes (attributed to consumers). Corporate income tax is not included due to uncertainty concerning the incidence of the tax. Individuals who are dependents of other taxpayers and taxpayers with negative income are excluded from the analysis.

(4) The average tax rate is equal to Federal taxes described in footnote (3) divided by income described in footnote (2).

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[Returns in Thousands; Dollars in Millions]

Calendar Year 2017

INCOME CATEGORY (2)	CHANGE IN FEDERAL TAXES (3)							
	All Returns		Single Filers		Joint Filers		Head of Household	
	Returns	Dollars	Returns	Dollars	Returns	Dollars	Returns	Dollars
Less than $10,000	785	-$60	562	-$9	92	$4	131	-$55
$10,000 to $20,000	4,149	-$6,154	2,955	-$4,031	426	-$522	768	-$1,601
$20,000 to $30,000	7,889	-$19,168	4,228	-$6,021	1,138	-$3,431	2,523	-$9,716
$30,000 to $40,000	9,396	-$18,744	4,694	-$2,857	2,006	-$6,138	2,696	-$9,749
$40,000 to $50,000	9,480	-$12,573	4,631	-$554	2,615	-$5,223	2,233	-$6,796
$50,000 to $75,000	19,375	-$12,007	7,621	$3,100	8,150	-$9,514	3,604	-$5,592
$75,000 to $100,000	14,038	$2,292	3,082	$1,695	9,619	$134	1,338	$464
$100,000 to $200,000	19,465	$14,387	2,326	$1,325	16,397	$12,545	743	$516
$200,000 to $500,000	4,845	$6,187	530	$792	4,200	$5,220	115	$175
$500,000 to $1,000,000	749	$2,360	79	$226	649	$2,066	22	$67
$1,000,000 and over	417	$3,454	49	$364	360	$3,016	9	$73
Total, All Taxpayers	**90,589**	**-$40,024**	**30,757**	**-$5,937**	**45,652**	**-$1,881**	**14,180**	**-$32,207**

Source: Joint Committee on Taxation
Detail may not add to total due to rounding.

(1) The proposal would impose a 40% excise tax at the insurer level on health coverage in excess of $8,500 for single plans and $23,000 for family plans. For retired individuals age 55 and over or those covered by a plan for high risk industries, the 40% excise tax would apply on health coverage in excess of $9,850 for single plans and $26,000 for family plans. Amounts would be indexed for inflation by the CPI-U plus one percentage point in years after 2013. The excise tax is nondeductible. The proposal would provide transition relief for the high 17 states. Under the proposal, refundable tax credits would be provided to taxpayers who enroll in exchange plans with income between 100 percent and 400 percent of FPL. The proposal provides for outlays in the form of cost-sharing subsidies for out-of-pocket medical expenses for exchange participants between 100% and 200% of FPL. The proposal increases the AGI threshold for the deduction of medical expenses from 7.5% to 10%, except age 65 and older. The proposal would increase the hospital insurance ("HI") tax by 0.5 percentage points on earning in excess of $200,000 ($250,000 for married couples filing jointly. The analysis includes the revenue effects of changes in excludable compensation due to the effects of the broader reform on employer sponsored coverage.

(2) The income concept used to place tax returns into income categories is adjusted gross income (AGI) plus: [1] tax-exempt interest, [2] employer contributions for health plans and life insurance, [3] employer share of FICA tax, [4] worker's compensation, [5] nontaxable Social Security benefits, [6] insurance value of Medicare benefits, [7] alternative minimum tax preference items, and [8] excluded income of U.S. citizens living abroad. Categories are measured at 2009 levels.

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Mr. GRASSLEY. In closing, let me turn to one more chart the Joint Tax Committee has provided. This chart shows the effect on the medical expense deduction limitation. This tax increase is just one of the many tax increases likely to stay in the new Democratic proposal. On this chart, which is for the year 2019, because that is when this bill is fully implemented, we see positive dollar figures. I have highlighted these dollar figures in yellow. For those who may not be able to see, I will reiterate that this chart only has positive dollar figures on it. But remember, as I explained yesterday, when we see positive dollar figures from the Joint Committee on Taxation, that committee is telling us that taxes for these people are going to go up. That means for all of the tax returns listed on this chart, taxes will be going up for each. And this tax increase, the medical expense deduction limitation, reaches as low as someone making $10,000 a year.

Maybe some of these low-income individuals and families who will see a tax increase under this provision will receive a subsidy for health insurance. These people may be able to offset this new tax liability. But you can bet your bottom dollar that a large portion of the middle-income individuals and families are not receiving a subsidy. This means that this tax liability highlighted in yellow cannot be offset by the government benefit.

My Democratic friends cannot escape that fact. Even if my friends drop some of the tax provisions in the current Reid bill, many tax provisions will most likely remain. And those tax provisions will increase taxes on middle-class Americans. This not only breaks President Obama's pledge, but it will arbitrarily burden middle-class Americans for years to come.

I yield the floor.

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

Mr. MENENDEZ. What is the pending business before the Senate?

The PRESIDING OFFICER. The conference report to accompany H.R. 3288.

Mr. MENENDEZ. I thank the Chair.

I rise about a program funded in that conference report. It is a program that we put under the framework of Cuba broadcasting. It is surrogate broadcasting into a closed society, a society for which the State controls all information or attempts to control all information to its 11 million citizens. It is a part of a long tradition of the United States with the Voice of America type of broadcasting, the effort to try to bring a free flow of information into countries in the world which are governed by despotic rulers. We did this successfully in the former Soviet Union. We did it successfully in Eastern Europe and during the changes in the Czech Republic, then Czechoslovakia, Poland, the Solidarity movement, and many others. We have been proud of that history of bringing the free flow of information. We now try to use it in different parts of the world based on the new challenges we have.

One of those places in the world in which we do this surrogate broadcasting is into the island of Cuba, because it has a repressive regime that will not allow the free flow of information to go to its people. We have a program called Radio and Television Marti. Marti is sort of like the George Washington of Cuba. It is named after him.

In 1983, Congress passed the Radio Broadcasting to Cuba Act to provide the people of Cuba, through Radio Marti, with information the Cuban Government would try to censor and keep from them. Subsequently in 1990, Congress authorized U.S. television broadcasting to Cuba through Radio and Television Marti to support the right of the Cuban people to receive information and ideas they would not normally receive. It opened radio and television broadcasting to Cuba, provided a consistently reliable and authoritative source of accurate, objective, and comprehensive news commentary and other information about events in Cuba and elsewhere. It did so to promote the cause of freedom inside of Cuba.

We know there is a long history of repressive regimes trying to block our surrogate broadcasting around the world. They just don't simply sit back and say: Send it all in. Let me accept whatever it is you are sending in. That is not their effort. Their effort is to block. And our difficulty with broadcasting has never been a justification for cutting funding for these programs. We have never submitted to the proposition that when a regime tries to block our surrogate broadcasting—whether it was Voice of America, Radio Free Europe, all of those efforts, there was always blocking taking place—that that is a cause or justification for cutting funding. It should not be a different standard now.

I ask, when it comes to Cuba broadcasting, why the double standard? In fact, especially now when change is coming to Cuba, it is in our interest to have the capacity to broadcast information to the Cuban people.

I want to show one of the charts that may be a little difficult back at home, but these are actual photographs which came from a January 2009 Government Accountability Office report which were provided by an organization that reports on Cuban affairs. It depicts evidence of Cubans' ability to watch Television Marti despite Cuban jamming efforts. These pictures were taken from inside of Cuba. They may not be the best picture quality, although I doubt they have digital television inside of Cuba. But nonetheless, they have the ability to see it.

There are other pictures of Cubans. Here is a picture of a group of individuals who, in fact, are part of an effort to create a library system, something as fundamental in the United States as a free public library. There isn't that in Cuba, at least not a free public library. They control what books might be found there.

So these groups try to create information. One of the things they do is, again, to be able to have access—as shown in this picture. This is a panel that is talking on Television Marti. Here, in this picture, is a young child watching a Marti program inside of Cuba. You can see the logo here of Marti TV.

As shown in this picture, this was a special that was broadcast into Cuba and was seen in Cuba on the Reverend Dr. Martin Luther King on the whole issue of peaceful, nonviolent change—as a message to the Cuban people that, in fact, these things could be achieved.

Now, you can see at the bottom of these pictures—it is a little hard to see—but here is the Marti logo that is seen on the bottom right-hand corner on several of these photographs.

This came from that Government Accountability Office report. A January 2009 report by the Government Accountability Office noted the following:

The Broadcasting Board of Governors—which is the oversight we have as the Federal Government—and the Office of Cuba Broadcasting and the U.S. Interests Section in Havana—which, in essence, is, we do not have an Embassy there because we do not have relations, but we have an Interests Section there—that Cuba officials emphasized that they face significant challenges in conducting valid audience research due to the closed nature of Cuban society.

U.S. government officials stationed in Havana are prohibited by the Castro regime from traveling outside of Havana.

We know it is difficult to travel to Cuba for the purpose of conducting audience research. We know the threat of Cuban Government surveillance and reprisals for interviewers and respondents raises concerns about respondents' willingness to answer sensitive questions frankly.

In this January 2009 Government Accountability Report, U.S. officials indicated that research on Radio and TV Marti's audience size faces significant limitations. For example, none of the data is representative of the entire Cuban population. Telephone surveys are the only random data collection effort in Cuba, but it might not be representative of Cuba's media habits for several reasons. But here are two of the main ones.

First, only adults in homes with published telephone numbers are surveyed. According to Broadcasting Board of Governors documents, approximately 17 percent of Cuban adults live in households with published household numbers. That means that 83 percent of the population does not have a published telephone number.

Second, the Board of Governors and the Office of Cuba Broadcasting officials noted that because individuals in

Cuba are discouraged or prohibited by their government from listening to and watching U.S. international broadcasts, they might be fearful of responding to media surveys and disclosing their media habits.

If I am told that it is illegal for me simply to watch the programming of some international organization, and that I can go to jail for listening to that programming, then ultimately—then ultimately—am I going to be truthful to some telephone survey about: Did I watch TV Marti? Did I listen to Radio Marti?

Mr. President, I know about this personally. Years ago, when I was in the House of Representatives, while I had an aunt who was still alive at the time, who I had asked never to acknowledge me as her nephew—which she agreed to—in my second term, however, she was listening to me on Radio Marti, and in a moment of pride, she said: ''Oh, that Menendez is my nephew.''

Unfortunately, she said it in front of some visitors who she thought were her friends. One of them was part of El Comite de Defensa de la Revolucion, which means ''The Committee to Defend the Revolution,'' a block watch organization in every city, in every village, in every hamlet inside Cuba, whose only job is to go and spy on their neighbors and tell the state security who speaks ill or does something against the regime.

Unfortunately, for that simple act of speaking out, saying to a friend: ''Oh, that Menendez is my nephew,'' my aunt suffered serious consequences.

So the audience size might very well be larger than the survey results would indicate because people are fearful to say: Yes, I am listening to Radio and Television Marti, because I cannot do that and not face the consequences of a regime that would arrest me.

Radio and TV Marti have a larger audience in Cuba. Why do I say that? Because a 2007 survey that the Office of Cuba Broadcasting commissioned, intended to obtain information on programming preferences and media habits, also contained data on Radio and TV Marti's audience size.

While the survey was not intended to measure listening rates or project audience size, this nonrandom survey of 382 Cubans, who had recently arrived in the United States—so now they were free to say what they actually did back at home because they were not subject to being arrested simply for listening to Radio and Television Marti—found that 45 percent of all of those respondents reported listening to Radio Marti and that over 21 percent reported watching TV Marti within the last 6 months before leaving Cuba.

So I rise because I want to bring this data, this information, this perspective to the debate.

I am happy to see the very deep cuts that were made to the Office of Cuba Broadcasting that contains both Radio and Television Marti have largely been restored. That is one of the reasons I felt willing to vote to proceed with the omnibus bill.

One of the body's greatest strengths is the ability to freely debate issues in an open format, issues on which, in the end, we might completely disagree, but issues that need to be brought into clear focus for the American people.

However, when I see my colleagues drawing conclusions on their own, without reasonable data to support those conclusions, I feel compelled to come and present an alternative perspective of the facts.

Why is this important to us. The United States is a beacon of light of freedom and democracy around the world. The promotion of democracy and human rights has always been one of the pillars of our foreign policy.

Yesterday was Human Rights Day, which is the day that marks the anniversary of the United Nations Assembly's adoption of the Universal Declaration of Human Rights in 1948. It is recognized every year on December 10.

Yesterday, in the midst of the recognition of this day in Havana, we saw the brutal Castro regime cracking down on people just because they were trying to exercise their right for peaceful demonstration. We saw people beaten, arrested, and forcibly detained.

There is a group of ladies; they call themselves the Ladies in White. They are mothers and sisters and friends of jailed dissidents inside of Cuba. So these are people of imprisoned family members—their son or their daughter, their brother or sister, their friends—and the only reason those people are in jail is because they have pursued peaceful means to try to create change inside of their own country. They may have said something. They may have worn a white band that says ''cambio,'' which means ''change.'' They may have simply uttered the fact that: What we need is change inside of Cuba.

So these Ladies in White—they dress fully in white so that, in fact, it is a form of being noticed, but, again, a peaceful form—held long-stem flowers and miniature Cuban flags. They were attacked by hundreds of angry pro-government demonstrators who sought to drown out their chants of ''freedom'' by yelling ''this street belongs to Fidel.''

Now, in Cuba, these groups are not spontaneous. It is not the citizenry. It is something called ''rapid response brigades.'' They are state security dressed as civilians, whose purpose is to make it seem that the populous is against the human rights activists and political dissidents. But, ultimately, they are state security agents who act in a way to make it seem quite different. But they are thugs.

Mr. President, the reason the regime organizes protests in this way is so if you orchestrate a protest, where it looks like its citizens are protesting against each other, then the regime can deny, in fact, any role in the event.

However, we know very well the role the Castro regime plays in these demonstrations. Especially in light of the events of yesterday and today, we know the Castro regime is a brutal totalitarian dictatorship that continues to violate the most basic human rights, continues to crush debate and crush dialog.

Yesterday, I came to the floor as part of my concerns and I spoke about this gentleman and his wife, as shown in this picture. I spoke about Jorge Luis Garcia Perez ''Antunez.'' This is a gentleman who said, while standing in a plaza in his hometown, which is in the center of Havana—it is not where the tourists go, not on the beaches of Havana; it is in the heart of Havana—he said what we need is the type of change we saw in Eastern Europe.

For that simple statement, he was thrown into jail for 17 years—17 years. He came out a couple years ago, but he has not changed. He has not changed his views or his effort to create human rights.

He issued a public letter that I read yesterday, an English translation, of a public letter he wrote to the present dictator, Raul Castro, the brother of Fidel Castro, and he said many things. I am not going to read the whole letter again, but he said things like: Let me ask you a few questions that I think are important.

> 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?

The very rights that are being observed in that international Human Rights Day of the Universal Declaration of Human Rights.

> 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—

Her brother; this is his wife shown in the picture—

> received in a Cuban prison.

I spoke about him yesterday and his letter. What happened today, Mr. President?

Today, the day after Human Rights Day, and the day after I read his letter into the RECORD, and 2 days after he presented that letter to Raul Castro, he was arrested again by the regime and arbitrarily detained with his wife and another activist.

What is his crime? That I read a letter in the U.S. Senate about his calls for freedom and democracy? And the day after the recognition of international human rights, he gets arrested today, and his wife gets arrested today—or detained today. I am not sure. He got arrested for sure.

TV Marti is one of the many efforts the U.S. Government rightly invests in to try to reach the Cuban people with information, to try to reach the people who were beaten today and yesterday and, for decades, simply for trying to demonstrate peacefully, to speak their mind, to walk in peace and in remembrance of their loved ones they lost under the clenched fists of this regime.

I feel badly that the day after I spoke about Mr. Antunez, he ends up in jail. So we need to have a spotlight, just as we did for Aleksandr Solzhenitsyn in the Soviet Union; just as we did for Vaclav Havel as he was trying to create change for the Czech Republic; just as we did with Lech Walesa when he was having the Solidarnosc Movement inside Poland.

For some reason, I can't get anybody to come to this floor and talk about the human rights violations inside Cuba. I hear a lot about: Let's trade with Cuba, let's do business with Cuba, let's travel to Cuba but, God, I never hear anyone talking about these human rights activists like the Lech Walesas, the Vaclav Havels, the Aleksandr Solzhenitsyns of that other time.

This man got arrested today simply because yesterday we made his letter public. That is the Castro regime that I know, not the romanticism of what some people have about what goes on at that island.

So I am pleased the Office of Cuba Broadcasting has made efforts over the last year to reevaluate the programs they are carrying out and carefully consider creative ways to reach the Cuban people. They have done this with Television Marti. They will continue to do this with other programs. I would expect nothing less. The kind of evaluation should continue. We should constantly strive to tailor our programs so our investments are reaching those who truly need our help, investments that are advancing U.S. foreign policy interests, the national interests of the United States, and the national security interests of the United States.

I have a declaration that came out of Cuba of over 100 human rights activists inside Cuba who are in support of the efforts of the United States as it relates to the surrogate broadcasting that goes into Cuba from Radio and Television Marti. This broadcasting provides some free flow of information of what is happening in the rest of the world, as well as what is happening inside Cuba. Because that is part of what we help here, to let those who otherwise would not know because of a closed society and a dictatorship that rules with an iron fist what is happening even inside their own country, what is happening to people such as Mr. Antunez, what is happening to the ladies in white who are protesting peacefully about their loved ones in jail.

Mr. MENENDEZ. With that letter of over 100 human rights activists is the recognition that we will not let up for Mr. Antunez and the recognition that there are voices who will continue to speak out for the human rights.

The last point I wish to make, imagine if you were sitting in a gulag somewhere, if you were beaten simply because you had a few words to say about creating change peacefully in your own country; imagine if you could be swept away by security police and taken to some jail and maybe not seen for years after that. Would you not want someone somewhere in the world to be standing and speaking for you? I would, and that is what I try to do on this floor.

With that, I yield the floor.

Mr. FEINGOLD. Mr. President, the massive, unamendable spending bill before the Senate includes three bills that the Senate never had a chance to consider, and is chock-full of earmarks. At a time of record budget deficits, we should be showing our constituents that we are serious about fiscal responsibility. Instead of controlling spending, this bill represents business as usual in Congress.

Mr. DEMINT. Mr. President, I rise today to address a question submitted to me from the good Senator from Illinois as to whether the DC Opportunity Scholarship Program will in fact end after this year. In order to respond to my colleague, I would like to highlight a particular section of the Financial Services and General Government Appropriations Act of 2010 that funds the District of Columbia's budget.

In title IV, which explains how the District of Columbia is funded, it states that $13.2 million will indeed be provided for opportunity scholarships for existing students in the DC Opportunity Scholarship Program. However, the very next line clearly states that the funds are to ''remain available until expended,'' which means that the program will eventually be phased out and terminated once the funding for current students is exhausted. Students in the program will slowly be phased out over time, unable to avail themselves of future educational opportunities currently given to them through this program.

The DC Opportunity Scholarship Program, which has the overwhelming support of DC residents, parents, Mayor Adrian Fenty, Chancellor Michelle Rhee, former Mayor Anthony Williams, and a majority of the DC City Council, has now been mandated a slow death by House and Senate appropriators. This scholarship program, which gives students of Washington, DC's poorest families a chance at a quality education, has now effectively been terminated since there is only funding available for existing scholarships and existing students, and not for future scholarships and future students.

By funding this program in such a manner in the omnibus, Congress is ultimately signaling the beginning of the end for this scholarship program. By disallowing future students to take part, the size of the program will shrink year after year, and will deny entry to siblings of existing participants—punishing many who have been waiting in line for this tremendous opportunity. Additionally, the federal evaluation of this program will be compromised as the numbers of participants diminishes, making it difficult for administrators to evaluate the effectiveness of the program.

The fact that this administration continues to claim that the DC Opportunity Scholarship Program is not being terminated is yet another act of deception on their part to the American people. The President, who himself is a recipient of a K–12 educational scholarship, has refused to stand up for children in our Nation's Capital and fight for the same educational opportunities afforded to him and his family—a right he exercises now as he practices school choice with his own children.

Mr. JOHNSON. Mr. President, working families are struggling to pay the costs of health care in this country. As the debate over health care reform progresses, we must keep in mind that Americans need and deserve quality, affordable health care. All too often families learn that the plan they could afford was not adequate when they needed it most.

I recently heard from Cory and Erin in Lake Herman, SD. They shared the story of their daughter's birth and how they discovered the inadequacies of their seemingly affordable health insurance policy. When Cory and Erin's daughter Katarzyna was born in 2006, Cory was working as an English and math teacher. At the time, the family health insurance plan available to him through the school district cost nearly 50 percent of his monthly salary. Cory chose instead to buy a catastrophic, high-deductible policy on the individual market for just over 10 percent of his income. Cory and Erin were healthy adults and had no major medical issues until the birth of their daughter. Their insurance policy did not cover prenatal or maternity care.

Wanting to be smart health care consumers, Cory and Erin shopped around for the best and most affordable hospital to welcome the birth of their first child and decided on their nearby community hospitial. However, when Katarzyna was born, she had a lung infection that required immediate action. Exhausted and worried for the health of their new baby girl, Cory and Erin had only moments to decide whether to airlift Katarzyna to a hospital with specialized care. At that moment, the last thing they could think about was the cost.

Katarzyna spent 3 nights in the Natal Intensive Care Unit of one of the State's largest hospitals, where she received top-notch care and survived the near-fatal pneumonia. The total cost came to $24,000, of which Cory and Erin's high-deductible insurance policy covered only $12,000. For the next several months, the family faced not only the challenges of a new baby but significant debt and a drawn-out struggle with their insurance company. They found a mistake with nearly every bill they received. Since this experience, Cory and Erin have purchased a new policy but worry that the insurance they can afford is not adequate in the face of another unforeseen medical emergency.

Like many Americans, Cory and Erin have health insurance. Despite their limited income, they took the responsibility to buy their own policy and

tried to be smart health care consumers. Their experience, however, illustrates the vulnerability of Americans who purchase insurance on the individual market, as well as the limits to which it is possible for Americans to be informed health care consumers.

The health care market does not function like other consumer markets. Ask your neighbor what a gallon of milk costs and they could tell you. Ask them how much it costs to have a baby and you would likely get a variety of answers, based entirely on their own experience with this important life event. The fact is the cost of having a baby depends. It depends on how much you pay for health insurance, what your insurance policy will cover and how much of that cost is your share. It depends on where you live, what complications may arise and whether the hospital nearby is equipped to handle an emergency.

The Patient Protection and Affordable Care Act will guarantee families access to affordable health insurance and coverage for essential benefits, including prenatal and maternity care. New health insurance exchanges in every State will provide a menu of quality, affordable health insurance plans for the self-employed and those who can't afford the coverage offered by their employer. Families who need assistance will be eligible for tax credits to make the plan of their choice affordable. Most importantly, families like Cory, Erin and Katarzyna's will have health insurance that covers life's essential needs. The birth of a child should not be a time to worry about what your health insurance will pay for or whether you can afford the treatment you need. Health care reform will give American families one less thing to worry about with the security of quality, affordable health care.

Mr. MENENDEZ. Mr. President, I ask unanimous consent that after any leader remarks on Saturday, December 12, the Senate then resume consideration of the conference report to accompany H.R. 3288, and that at 9:30 a.m., the Senate proceed to vote on the motion to invoke cloture on the conference report, with the time until 9:30 a.m. equally divided and controlled between the leaders or their designees; further, that if cloture is invoked, then postcloture time continue to run during any recess, adjournment, or period of morning business; that on Sunday, December 13, all postcloture time be considered expired at 2 p.m., and the Senate proceed to vote on the adoption of the conference report to accompany H.R. 3288.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

MORNING BUSINESS

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

TRIBUTE TO CAROL BORNEMAN

Mr. MCCONNELL. Mr. President, today I would like to recognize an outstanding Kentuckian for her talented efforts to entertain and educate the public about the Cumberland Gap National Historic Park. Ranger Carol Borneman is the recipient of the 2009 Freeman Tilden Award for the southeast region of the National Park Service. Ranger Carol, as she is commonly known from her television show, ''Wild Outdoor Adventures with Ranger Carol,'' has been with the Cumberland Gap National Historical Park for over 15 years and serves as the park's supervisory interpreter.

The Cumberland Gap, through the Cumberland Mountains and near the Kentucky-Virginia border, was America's historical gateway to the West. Ranger Carol's stories bring to life the travel experiences of America's earliest western settlers in a way that is both educational and memorable.

There is no doubt that it is Ranger Carol's love for the park that keeps her stories entertaining. Mark Woods, Superintendent of the Cumberland Gap National Historical Park, stated that ''she truly has a passion for the work that she does and it definitely comes through on the show. . . . You cannot watch the show without being captivated by Carol's knowledge, dedication, and sheer enthusiasm.''

The Freeman Tilden Award is the most prestigious award given in the field of interpretation and education within the National Park Service. Borneman is not new to such an honor; in fact, this is the second time she has received it. It is with great pride that I rise today to ask my colleagues to join me in congratulating Ranger Carol Borneman on receiving the Freeman Tilden Award, and for her outstanding efforts to keep important Kentucky history alive for future generations to enjoy.

REMEMBERING A. ROBERT DOLL

Mr. MCCONNELL. Mr. President, today I would like to reflect on the life of a dear friend, the late A. Robert Doll. Bob, as he was affectionately known, was a well-known lawyer, leader, and volunteer in his beloved Louisville community. His passing is a great loss, but his legacy lives on in the business and organizations he so dearly loved.

Mr. Doll was a founding member of the law firm Greenebaum, Doll & McDonald in Louisville. He joined the firm in the 1950s after receiving his law degree from the College of William and Mary. During his 50-plus years with Greenebaum, Doll & McDonald, Bob helped the firm grow from a mere 20 lawyers to a firm with multiple offices and 120 lawyers. When Bob was just 30 years old, he argued and won a case before the U.S. Supreme Court.

Mr. Doll showed his respect for his customers with the motto, ''I believe that a successful law firm must emphasize and create the delivery of prompt and exceptional legal service to the client—we must remember that the client is king.'' One of the great successes of his career was helping to bring the Toyota plant to Scott County. He also served as the president of the Louisville Bar Foundation. In 1986, Mr. Doll was named Lawyer of the Year by the Louisville Bar Association.

Bob was also active in his community, as he served as president of the Greater Louisville YMCA board of directors and maintained a leading role in the Boy Scouts of America. Phillip Scott, the current firm chairman of Greenebaum, Doll & McDonald, stated that ''Mr. Doll was not just a great lawyer, but a great man and great leader. He was a progressive leader who made Greenebaum the firm it is today. We deeply value the friendship, ideals and character he bestowed upon on us, and we'll miss him greatly.''

As a leader in his community, Bob Doll was a man of integrity who made a real positive impact in the Commonwealth. His devotion for creating and maintaining a client-focused business shows he always cared about serving the community first. He will be missed by all who had the pleasure of knowing him, and I ask that my colleagues join me in paying tribute to the wonderful life of Mr. A. Bob Doll.

EL SALVADOR

Mr. LEAHY. Mr. President, I want to briefly discuss a subject that should interest all Senators concerning the country of El Salvador, which recently elected a new President and last month suffered extensive loss of life and devastating property damage as a result of torrential rains caused by Hurricane Ida.

First, I congratulate the people of El Salvador on the election, which was historic in that President Funes is the country's first President since the end of the civil war who is a member of the FMLN, which after the 1992 Peace Accords evolved from an armed insurgency into a political party. I am encouraged by what I have heard about President Funes' policies and wish him the best.

Second, the destruction caused by Hurricane Ida was extensive. Exceptionally heavy and constant rain fell on November 7 and 8, resulting in flooding and landslides that killed 192 people. Another 80 were reported missing, and more than 14,295 others were displaced from their homes. Thousands of homes, as well as roads, bridges, and other public buildings, were damaged or destroyed.

On November 10, U.S. Chargé d'Affaires Robert Blau declared a disaster in response to the damage, and the U.S. Agency for International Development has so far allocated some $280,851 in humanitarian aid. An assessment of the

total damage is underway, but it is expected to be in the hundreds of millions, if not billions, of dollars.

Congressman JIM MCGOVERN and I have urged the administration to provide additional aid. We remember how the U.S. Government all but forgot about El Salvador after the war ended, and this is a time to help the Salvadoran people recover from this tragedy.

Third, an issue that has deeply concerned me for many years is the problem of corruption and impunity in El Salvador. The police and the courts lack the training and resources they need, crimes are rarely solved and perpetrators are rarely punished. Violent crime and corruption have become endemic. El Salvador's democratic and economic development will continue to be impeded by a justice system that is incapable of enforcing the rule of law, and in which the Salvadoran people and foreign investors have little confidence.

One of the courageous Salvadorans who is trying to change this is Ms. Zaira Navas, inspector general of the National Police. She has a woefully inadequate budget and too few staff. But despite that, from everything I have heard she is doing an outstanding job for justice and the people of El Salvador.

I mention Ms. Navas because of the critical importance of the job she is doing, and because she has recently received death threats and I am concerned for her safety. I urge officials at the U.S. Embassy to discuss with President Funes what steps can be taken immediately to provide her the security she needs, and to increase the budget of her office.

El Salvador is a small country but one with which the U.S. has a long history. We both have newly elected presidents, and I am hopeful that we will see a renewed effort to work together to broaden our relations. Nothing, in my view, is more important than strengthening the rule of law and supporting people like Ms. Navas, but we should also expand our collaboration in health, education and exchanges, the environment, trade and investment, science and technology, the arts and culture.

CONGO

Mr. FEINGOLD. Mr. President, last month, the United Nations Group of Experts on the Democratic Republic of Congo presented its latest report to the U.N. Security Council. Over the years, the Group of Experts has conducted critical investigations into violations of the sanctions and the U.N. arms embargo toward Congo as well as human rights abuses and the linkages between natural resource exploitation and the financing of illegal armed groups. Yet, too often, the Group of Experts' reports and recommendations have not resulted in action by the Security Council and/or U.N. member states. I hope it will be different with this report, especially since it identifies a number of concrete steps through which U.N. member states can address the financial and support networks that fuel the violence in eastern Congo.

This new Group of Experts report particularly focuses on the FDLR, the armed group comprising many former Rwandan génocidaires that is at the heart of the instability in eastern Congo. It documents how this group continues to benefit from ''residual but significant support'' from top commanders of the Congolese military. It also documents how this group is supported by a far-reaching international Diaspora network. Based on records of satellite phones, the Group of Experts found that the FDLR commanders frequently communicate with people in twenty-five different countries in Europe, North America and Africa. The report also mentions credible reports and testimony that the FDLR is using Burundi ''as a rear base'' for regrouping and recruitment purposes.

To address these continued support networks, the Group of Experts recommends that U.N. member states direct their respective law enforcement and security agencies to conduct investigations and share relevant information on FDLR Diaspora members providing material support to the group. The Group also calls on member states to prosecute violations of the sanctions regime by their nationals or leaders of armed groups that are currently residing within their countries. The report cites three such leaders who have resided in France and Germany. With regard to the Congolese military, the Group recommends that the Security Council require member states to notify and get approval from the Sanctions Committee for all deliveries of military equipment and provision of training to Congo. This would help ensure that international assistance is not contributing to abusive behavior or going to units of the military believed to be colluding with armed groups.

Building on its previous reports, the Group of Experts report also shows how the FDLR and other armed groups continue to benefit from the exploitation of natural resources. According to this Group's investigations, the FDLR continues to get millions of dollars in direct financing from gold and cassiterite reserves in eastern Congo. The report illustrates how gold from eastern Congo is smuggled out to Uganda and Burundi, and then travels on to the United Arab Emirates and ultimately international markets. Similarly, the report documents how former rebels of the CNDP—who have ostensibly become part of the Congolese military—continue to control and exploit mineral-rich areas. In fact, two of the most lucrative mining sites are reportedly controlled by units of the Congolese military that are composed almost exclusively of former CNDP units. This is especially worrying in the context of the CNDP's integration into the Congolese military, which is still extremely fragile.

I have long called for action to address the armed exploitation of Congo's minerals, which fuels this conflict. I was pleased to join with Senators BROWNBACK and DURBIN earlier this year to introduce the Congo Conflict Minerals Act, S. 891, which would commit the United States to address this issue comprehensively. And I was glad that Secretary Clinton spoke about this issue during her visit to Congo in August. As the Group of Experts report makes clear, armed groups will continue to exploit the region's rich mineral base as long as it is profitable. The Group of Experts recommends that member states take necessary measures to clarify the due diligence obligations of companies under their respective jurisdictions that operate with these minerals. The Group also calls for the Congolese government to establish an independent monitoring team, with international support, to conduct spot checks of mines and mineral trading routes.

I am glad that there is increasing outrage about what is happening in eastern Congo. It is the single deadliest conflict since the Second World War and millions have been displaced from their homes, forced to live in squalid conditions. Countless women and girls and some men and boys in the Congo have endured rape and sexual violence. But our outrage means little unless it translates into concrete actions to fundamentally change the situation in Congo. We need to finally get serious about addressing the underlying issues that make this war profitable and allow it to persist. The Group of Experts has provided a clear picture of some of those issues as well as specific ways that U.N. member states can address them, including within our own national jurisdictions. I applaud the Group for its courageous work. I strongly hope that the Security Council will pursue the report's recommendations, and I urge the Obama administration to lead the way in this respect.

RECOGNIZING WREATHS ACROSS AMERICA

Ms. SNOWE. Mr. President, today I pay tribute to Wreaths Across America and Morrill and Karen Worcester, whose outstanding vision of a nationwide effort to extol America's fallen heroes is now in its 18th year!

Nothing could be more central to the Wreaths Across America organization—which counts among its many tremendous volunteers and partners, The Maine State Society of Washington, DC, the Civil Air Patrol, the Patriot Guard Riders, and members of The American Legion and Veterans of Foreign Wars—than its noble mission to remember those who made the ultimate sacrifice, honor those who serve, and teach our children that today's freedoms have been won at a great price. And how fitting it is that

Mainers across our State ushered in this week of solemn events and wreath-laying ceremonies sponsored by Wreaths Across America, the culmination of which will be the delivery of as many as 16,000 wreaths for placement at Arlington National Cemetery on December 12 as well as observances in more than 400 participating locations nationwide, including 24 overseas veterans cemeteries. Indeed, I could not have been more gratified to join Senator COLLINS in introducing legislation, designating December 12, 2009, as ''Wreaths Across America Day'' which passed the Senate unanimously on the first of this month.

What an inexpressible source of pride it is that tomorrow, on the morning of the 12th, a convoy of Mainers is scheduled to arrive at Arlington National Cemetery to lay Maine-made balsam wreaths at the grave sites of our Nation's fallen heroes. The Patriot Guard Riders will continue their tradition of escorting tractor-trailers filled with wreaths donated by Worcester Wreath Company in Harrington, ME, to Arlington National Cemetery. On a personal note, I well recall the Worcester's initiating the Arlington Wreath Project in December of 1992, when Morrill called my office to ask if he could place his excess wreaths on the graves at Arlington National Cemetery. I never could have imagined that what occurred then would someday evolve into a nationwide expression of unfailing gratitude to our troops.

The enduring legacy of our bravest and finest for whom service above self and country above self-interest is woven into the fabric of our greatness is a powerful reminder that freedom is not free, especially as the indelible memories of those heroes who, in the immortal words of President Lincoln ''gave the last full measure of devotion,'' are etched forever in our minds and upon our hearts. We also owe an enormous debt of gratitude to the men and women extraordinary enough to wear the uniform who are currently serving in harm's way and placing their lives on the line on our behalf, especially in Iraq and Afghanistan. Indeed, what a fitting remembrance this annual gesture of reverence and gratefulness by Wreaths Across America represents, especially during this joyous season of giving, for those who have bequeathed this great land so much, and for whom we are truly grateful.

TRIBUTE TO FIRST SERGEANT BRADLEY G. SIMMONS

Mr. BROWN. Mr. President, I rise to honor 1stSgt Bradley G. Simmons, U.S. Marine Corps, for his year of service to the U.S. Senate and for his continuing service to our Nation and the Marine Corps.

For the past year, 1stSgt Bradley Simmons has worked in my office and served the people of Ohio as the first enlisted Marine fellow in the U.S. Senate.

Before joining the Senate, 1stSgt Bradley Simmons served in Kuwait with the 3rd Assault Amphibian Battalion. He also participated in the initial attack and continuing operations in Iraq.

His heroic service as an AAV section leader during that time earned him the Navy and Marine Corps Commendation Medal and a combat distinguishing device for valor.

1stSgt Bradley Simmons' strength, dedication, and firsthand experience overseas made him an invaluable resource for my staff and our Nation's service members and veterans.

Understanding of the difficult transition for returning service members and veterans, 1stSgt Bradley Simmons reached out to help them and their families in tangible ways.

From helping Ohio veterans with their VA claims; to assisting a wounded service member during rehabilitation; to meeting and speaking with the families whose loved ones are overseas, 1st Sgt Bradley Simmons demonstrated an unequivocal commitment to his fellow service members.

His tireless work on the Visions Scholars Act of 2009 will help ensure that veterans suffering from eye injuries would not also suffer from the current nationwide shortage of visions specialists at the VA.

The Vision Scholars Act of 2009 passed the Senate last month with great assistance from Sergeant Simmons.

But 1stSgt Bradley Simmons has been more than a trusted adviser.

He's been a teacher and a friend. As First Sergeant Simmons likes to say, he has been running a full-scale Marine Corps familiarization program in my office for the past year.

With a story-telling talent that left you laughing, with a moment of contemplation on the life of a marine, or with a little PT encouragement for the deskbound, First Sergeant Simmons made us appreciate the leadership qualities that are found throughout the ranks of the Marine Corps, but especially in him.

From interns in my office to constituents in the State, to all of my staff in Ohio and Washington, he succeeded in educating us about the honor, tradition, and sacrifices readily made by our Marines and our military forces.

He made us better at our jobs and better citizens in our communities.

He accompanied me to Walter Reed to visit troops recovering from combat injuries and later assisted in helping a few of them transition to life as a civilian, or on active duty in the guard or reserve.

He invited my staff to the Pentagon to a welcome home those recently injured in Iraq and Afghanistan.

During this past year, First Sergeant Simmons taught us about the determination and commitment of the men and women who give honor to the Marine Corps.

A lot has changed in the past year for our office, and for 1stSgt Bradley Simmons as well. First Sergeant Simmons came to my office as a gunnery sergeant.

At his promotion ceremony a few weeks back, his superiors explained that the Marine Corps does not base promotion in rank on previous performance and accomplishment.

Instead, promotion is based on a candidate's innate capability and potential to do the job well and the rank of first sergeant justice.

Like his superiors, I am as confident that he will succeed in anything he attempts and that he demonstrates the courage and commitment that we recognize in him.

His humility belies his dedicated service to our Nation. It provides great comfort knowing that hundreds of marines will have the opportunity to work, live, learn, and serve with First Sergeant Simmons.

He is a testament to the Marines, to our Nation, to his family, and to his home State of Kansas.

And to Karen, his wife, thank you for your support and sacrifice while your husband serves this Nation. I enjoyed meeting you and I know that 1stSgt Bradley Simmons can do what he does because of your love and support.

After having the privilege of working with First Sergeant Simmons over the past year and seeing the lasting mark he has left on my office, I am honored to have someone of his caliber and commitment representing our Nation.

Thank you, 1stSgt Bradley G. Simmons, for your distinguished service to the people of Ohio and for your continued commitment to protecting our Nation and the prosperity of all Americans.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 10:47 a.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 4017. An act to designate the facility of the United States Postal Service located at 43 Maple Avenue in Shrewsbury, Massachusetts, as the ''Ann Marie Blute Post Office''.

At 3:00 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res. 62. Joint resolution appointing the day for the convening of the second session of the One Hundred Eleventh Congress.

The message further announced that pursuant to section 1238(b)(3) of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (22 U.S.C. 7002), as amended by division P of the Consolidated Appropriations Resolution, 2003 (22 U.S.C. 6901), the Minority Leader re-appoints the following members on the part of the House of Representatives to the United States-China Economic and Security Review Commission, effective January 1, 2010: Mr. Peter T.R. Brookes of Virginia and Mr. Daniel M. Slane of Ohio.

MEASURES REFERRED

The following bill was read the first and the second times by unanimous consent, and referred as indicated:

H.R. 4017. An act to designate the facility of the United States Postal Service located at 43 Maple Avenue in Shrewsbury, Massachusetts, as the ''Ann Marie Blute Post Office''; to the Committee on Homeland Security and Governmental Affairs.

MEASURES PLACED ON THE CALENDAR

The following bill was read the first and second times by unanimous consent, and placed on the calendar:

H.R. 1506. An act to provide that claims of the United States to certain documents relating to Franklin Delano Roosevelt shall be treated as waived and relinquished in certain circumstances.

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–3981. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''National Veterinary Accreditation Program'' (Docket No. APHIS–2006–0093) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3982. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Swine Health Protection; Feeding of Processed Product to Swine'' (Docket No. APHIS–2008–0120) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3983. A communication from the Chairman, Board of Governors of the Federal Reserve System, transmitting, pursuant to law, a report relative to the Buy American Act; to the Committee on Banking, Housing, and Urban Affairs.

EC–3984. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''New Qualified Plug-in Electric Drive Motor Vehicle Credit'' (Notice No. 2009–89) received in the Office of the President of the Senate on December 4, 2009; to the Committee on Finance.

EC–3985. 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 Japan relative to the design and manufacture of propellant actuated devices for F–15J Aircraft; to the Committee on Foreign Relations.

EC–3986. 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 amendment to a manufacturing license agreement for the export of defense articles, including, technical data, and defense services to Mexico relative to the design and manufacture of Military Flexible Printed Circuit Board Assemblies (Flex Circuits) in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3987. 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 amendment to a manufacturing license agreement for the export of defense articles, including, technical data, and defense services to Japan relative to the design, manufacture, and repair of the Japan PATRIOT Product Improvement Program in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3988. 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 technical assistance agreement for the export of defense articles, including, technical data, and defense services to Israel relative to the design, manufacture, and delivery of tactical computers and data processing and communications systems in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3989. 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 technical assistance agreement for the export of defense articles, including, technical data, and defense services to Canada to support the sale of C–130J Hercules Aircraft in the amount of $100,000,000 or more; to the Committee on Foreign Relations.

EC–3990. 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 technical assistance agreement for the export of defense articles, including, technical data, and defense services to the United Kingdom relative to the design and manufacture of Wing Trailing Edge Panels and Flap Hinge Fairings for the C–17 Globemaster III Transport Aircraft in the amount of $100,000,000 or more; to the Committee on Foreign Relations.

EC–3991. A communication from the Secretary, Department of Agriculture, 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–3992. A communication from the Acting Chairman, Equal Employment Opportunity 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–3993. A communication from the Assistant Deputy Associate Administrator for Acquisition Policy, General Services Administration, Department of Defense and National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled ''Federal Acquisition Regulation; Federal Acquisition Circular 2005–38'' received in the Office of the President of the Senate on December 9, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3994. A communication from the Chief Human Capital Officer, Small Business Administration, transmitting, pursuant to law, a report relative to a vacancy in the position of Chief Counsel for Advocacy, received in the Office of the President of the Senate on December 8, 2009; to the Committee on Small Business and Entrepreneurship.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. LEAHY, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 448. A bill to maintain the free flow of information to the public by providing conditions for the federally compelled disclosure of information by certain persons connected with the news media.

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. CARPER (for himself, Mr. ALEXANDER, Mr. BYRD, Mr. LIEBERMAN, Mr. VOINOVICH, Mr. WARNER, and Mr. WEBB):

S. 2872. A bill to authorize appropriations for the National Historical Publications and Records Commission through fiscal year 2014, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. BEGICH:

S. 2873. A bill to amend the Internal Revenue Code of 1986 to deny the deduction for direct to consumer advertising expenses for prescription pharmaceuticals and to provide a deduction for fees paid for the participation of children in certain organizations which promote physical activity; to the Committee on Finance.

By Ms. LANDRIEU:

S. 2874. A bill to designate the facility of the United States Postal Service located at 2000 Louisiana Avenue in New Orleans, Louisiana, as the ''Ray Rondeno, Sr. Post Office Building''; to the Committee on Homeland Security and Governmental Affairs.

By Mr. FEINGOLD:

S. 2875. A bill to establish the Commission on Measures of Household Economic Security to conduct a study and submit a report containing recommendations to establish and report economic statistics that reflect the economic status and well-being of American households; to the Committee on Homeland Security and Governmental Affairs.

By Ms. LANDRIEU:

S. 2876. A bill to amend the Internal Revenue Code of 1986 to clarify the capital gain

or loss treatment of the sale or exchange of mitigation credits earned by restoring wetlands, and for other purposes; to the Committee on Finance.

By Ms. CANTWELL (for herself and Ms. COLLINS):

S. 2877. A bill to direct the Secretary of the Treasury to establish a program to regulate the entry of fossil carbon into commerce in the United States to promote clean energy jobs and economic growth and avoid dangerous interference with the climate of the Earth, and for other purposes; to the Committee on Finance.

By Mrs. GILLIBRAND:

S. 2878. A bill to prevent gun trafficking in the United States; to the Committee on the Judiciary.

By Mr. ROCKEFELLER (for himself, Mrs. HUTCHISON, Mr. KERRY, Ms. SNOWE, Mr. PRYOR, and Mr. WARNER):

S. 2879. A bill to direct the Federal Communications Commission to conduct a pilot program expanding the Lifeline Program to include broadband service, and for other purposes; to the Committee on Commerce, Science, and Transportation.

ADDITIONAL COSPONSORS

S. 605

At the request of Mr. KAUFMAN, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 605, a bill to require the Securities and Exchange Commission to reinstate the uptick rule and effectively regulate abusive short selling activities.

S. 730

At the request of Mr. ENSIGN, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 730, a bill to amend the Harmonized Tariff Schedule of the United States to modify the tariffs on certain footwear, and for other purposes.

S. 812

At the request of Mr. BAUCUS, the name of the Senator from South Dakota (Mr. JOHNSON) 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. 1067

At the request of Mr. BROWNBACK, the name of the Senator from California (Mrs. FEINSTEIN) 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. 1389

At the request of Mr. NELSON of Nebraska, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 1389, a bill to clarify the exemption for certain annuity contracts and insurance policies from Federal regulation under the Securities Act of 1933.

S. 1524

At the request of Mr. KERRY, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 1524, a bill to strengthen the capacity, transparency, and accountability of United States foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.

S. 1589

At the request of Ms. CANTWELL, the names of the Senator from Missouri (Mr. BOND) and the Senator from Illinois (Mr. BURRIS) were added as cosponsors of S. 1589, a bill to amend the Internal Revenue Code of 1986 to modify the incentives for the production of biodiesel.

S. 1790

At the request of Mr. DORGAN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 1790, a bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1932

At the request of Mr. BENNET, the name of the Senator from Missouri (Mrs. MCCASKILL) 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. 2776

At the request of Mr. ALEXANDER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 2776, a bill to amend the Energy Policy Act of 2005 to create the right business environment for doubling production of clean nuclear energy and other clean energy and to create mini-Manhattan projects for clean energy research and development.

S. 2777

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 2777, a bill to repeal the American Recovery Capital loan program of the Small Business Administration.

S. 2833

At the request of Mr. REED, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of S. 2833, a bill to provide adjusted Federal medical assistance percentage rates during a transitional assistance period.

S. 2843

At the request of Ms. STABENOW, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 2843, a bill to provide for a program of research, development, demonstration, and commercial application in vehicle technologies at the Department of Energy.

S. 2852

At the request of Mr. BEGICH, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 2852, a bill to establish, within the National Oceanic and Atmospheric Administration, an integrated and comprehensive ocean, coastal, Great Lakes, and atmospheric research, prediction, and environmental information program to support renewable energy.

S. 2869

At the request of Ms. LANDRIEU, the names of the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. LIEBERMAN), the Senator from New Hampshire (Mrs. SHAHEEN) and the Senator from North Dakota (Mr. DORGAN) were added as cosponsors of 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.

S. CON. RES. 20

At the request of Mr. BYRD, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. Con. Res. 20, a concurrent resolution authorizing the last surviving veteran of the First World War to lie in honor in the rotunda of the Capitol upon his death.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the names of the Senator from Hawaii (Mr. AKAKA), the Senator from Alaska (Mr. BEGICH) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2827

At the request of Mr. TESTER, the name of the Senator from Colorado (Mr. UDALL) was added as a cosponsor of amendment No. 2827 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2878

At the request of Mr. CARDIN, the names of the Senator from Massachusetts (Mr. KERRY) and the Senator from Alaska (Mr. BEGICH) 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. 2879

At the request of Mr. CARDIN, the name of the Senator from Wisconsin

(Mr. KOHL) was added as a cosponsor of amendment No. 2879 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. 2904

At the request of Ms. SNOWE, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of amendment No. 2904 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 Pennsylvania (Mr. SPECTER) 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. 2924

At the request of Mr. CASEY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of amendment No. 2924 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 names of the Senator from Minnesota (Mr. FRANKEN), the Senator from Massachusetts (Mr. KIRK) and the Senator from Pennsylvania (Mr. CASEY) were added as cosponsors 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. 3011

At the request of Ms. LANDRIEU, the name of the Senator from Mississippi (Mr. WICKER) 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. 3037

At the request of Mr. JOHNSON, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of amendment No. 3037 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. 3101

At the request of Mr. FRANKEN, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of amendment No. 3101 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 name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor 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.

AMENDMENT NO. 3112

At the request of Ms. CANTWELL, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of amendment No. 3112 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. 3114

At the request of Mr. GRASSLEY, the names of the Senator from Nevada (Mr. REID) and the Senator from Montana (Mr. TESTER) were added as cosponsors of amendment No. 3114 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. 3119

At the request of Mr. WARNER, the names of the Senator from Delaware (Mr. CARPER), the Senator from Maine (Ms. SNOWE) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of amendment No. 3119 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. 3132

At the request of Mrs. MCCASKILL, the name of the Senator from Virginia (Mr. WEBB) was added as a cosponsor of amendment No. 3132 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.

STATEMENT ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CARPER (for himself, Mr. ALEXANDER, Mr. BYRD, Mr. LIEBERMAN, Mr. VOINOVICH, Mr. WARNER, and Mr. WEBB):

SA 2872. A bill to authorize appropriations for the National Historical Publications and Records Commission through fiscal year 2014, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. CARPER. Mr. President, I rise today with my colleagues to introduce an important and bipartisan piece of legislation that will help protect our Nation's history for future generations.

Our bill reauthorizes the National Historical Publications and Record Commission, or NHPRC for short, which was first established by Congress in 1934. The Commission is the grant-making body of the National Archives and Records Administration and is comprised of representatives from the President of the United States, the U.S. Senate and House of Representatives, the Federal judiciary, the Departments of State and Defense, the Library of Congress, and six national, professional associations of archivists. Since 1964, the Commission has funded projects that locate, preserve, and provide public access to some our nation's most precious historical resources that otherwise would be lost and destroyed.

For example, some of the history that has been preserved by the NHPRC over the years has helped award-winning historian David McCullough write his biography of John Adams and Pulitzer Prize-winner Ron Chernow write his biography of Alexander Hamilton. Further, the NHPRC has helped establish or modernize public records programs in cities all across America such as the cities of Seattle, Boston, and San Diego. The NHPRC also has been the key federal body to help preserve the oral histories of many Native American tribes such as the Seneca, Blackfoot, Sioux, Navajo, Apaches, and dozens more.

Further, I am proud to say that the NHPRC recently sped up and digitized over 5,000 documents left behind by our Nation's founding fathers that were previously unpublished. Congress passed legislation last year that I was honored to co-author with our former colleague, Senator John Warner from Virginia, requiring the NHPRC to work with the groups publishing the volumes so that the documents could be made available online at no charge to any student of history. Before, they were walled-up behind the doors of large libraries and expensive to access. To put that into context, the NHPRC has saved anyone who needs to view the letters of John Adams thousands of dollars, which would have been the traditional cost of a complete set of published letters.

Lastly, the bill I am introducing today removes an artificial profit cap that Congress put in place a few years

ago that prevents the National Archives and Records Administration from operating its regional facilities more like a business. For example, there are times at the end of the year when the revolving fund that pays for the operation and maintenance of the regional archival facilities earns a profit. Instead of incentivizing the National Archives to save the excess profit for long-term capital investments, the cap incentivizes regional facilities to spend the money on short term projects that they may not be needed. This simply does not make sense for the National Archives or for the taxpayer.

I look forward to working with my colleagues to get this important and necessary bill enacted before it's too late. I think everyone can agree that one of the things our democracy relies on is educated citizenry. The NHPRC is the principle body that helps make that happen.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2872

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

SECTION 1. AUTHORIZATION OF APPROPRIATIONS THROUGH FISCAL YEAR 2014 FOR NATIONAL HISTORICAL PUBLICATIONS AND RECORDS COMMISSION.

Section 2504(g)(1) of title 44, United States Code, is amended—

(1) in subparagraph (R), by striking ''and'';

(2) in subparagraph (S), by striking the period and inserting ''; and''; and

(3) by adding at the end of the following:

''(T) $13,000,000 for fiscal year 2010, $13,500,000 for fiscal year 2011, $14,000,000 for fiscal year 2012, $14,500,000 for fiscal year 2013, and $15,000,000 for fiscal year 2014.''.

SEC. 2. INCREASED FLEXIBILITY FOR ARCHIVIST IN THE RECORDS CENTER REVOLVING FUND.

Subsection (d) under the heading ''RECORDS CENTER REVOLVING FUND '' in title IV of the Independent Agencies Appropriations Act, 2000 (Public Law 106-58; 113 Stat. 460; 44 U.S.C. 2901 note), is amended—

(1) in paragraph (1), by striking ''not to exceed 4 percent'' and inserting ''determined by the Archivist of the United States''; and

(2) in paragraph (2), by striking ''Funds in excess of the 4 percent at the close of each fiscal year'' and inserting ''Any unobligated and unexpended balances in the Fund that the Archivist of the United States determines to be in excess of those needed for capital equipment or a reasonable operating reserve''.

SEC. 3. GRANTS FOR ESTABLISHMENT OF STATE AND LOCAL DATABASES FOR RECORDS OF SERVITUDE, EMANCIPATION, AND POST-CIVIL WAR RECONSTRUCTION.

Section 8 of the Presidential Historical Records Preservation Act of 2008 (44 U.S.C. 2504 note) is amended to read as follows:

''SEC. 8. GRANTS FOR ESTABLISHMENT OF STATE AND LOCAL DATABASES FOR RECORDS OF SERVITUDE, EMANCIPATION, AND POST-CIVIL WAR RECONSTRUCTION.

''(a) IN GENERAL.—The Archivist of the United States, after considering the advice and recommendations of the National Historical Publications and Records Commission, may make grants to States, colleges and universities, museums, libraries, and genealogical associations to preserve records and establish electronically searchable databases consisting of local records of servitude, emancipation, and post-Civil War reconstruction.

''(b) MAINTENANCE.—Any database established using a grant under this section shall be maintained by appropriate agencies or institutions designated by the Archivist of the United States.''.

By Mr. FEINGOLD.

S. 2875. A bill to establish the Commission on Measures of Household Economic Security to conduct a study and submit a report containing recommendations to establish and report economic statistics that reflect the economic status and well-being of American households; to the Committee on Homeland Security and Governmental Affairs.

Mr. FEINGOLD. Mr. President, our government agencies collect and report a range of economic information but much of what we see or hear is most suited to describing the general state of the country's economy. This information does not reflect what is happening in and what matters most to our families and the quality of our lives. For example, our national unemployment figures don't tell us that those who are employed may not have benefits, or that they are working two or three jobs to earn the income that they report, or that their mortgage debt and college loans are jeopardizing their ability to repay their credit card debt or their medical bills. By knowing and reporting this kind of information we can not only more accurately reflect what our families are experiencing economically, we can better inform policymakers about what matters most to people and the steps that need to be taken to address household economic needs and concerns.

To address this need I am re-introducing the Commission on Measures of Household Economic Security Act of 2009. The bill would establish a bipartisan congressional commission of 8 economic experts to look at existing government economic data and identify the possible need for new information, more accurate methodologies and better ways to report these economic measures to give a more accurate and reliable picture of the economic well being of American households. As part of their effort, the Commission will be asked to meet with representative groups of the public so that their views are taken into account in the Commission's recommendations.

In doing this, the Commission will look at such things as the current debt situation of American individuals and households, including categories of debt such as credit card debt, education related loans and mortgage payments; the movement of Americans between salaried jobs with benefits to single or multiple wage jobs with limited or no benefits with a comparison of income to include the value of benefits programs such as health insurance and retirement plans; the percentage of Americans who are covered by both employer-provided and individual health care plans and the extent of coverage per dollar paid by both employers and employees; the savings rate, including both standard savings plans and pension plans; the disparity in income distribution over time and between different demographic and geographic groups; and the breakdown of household expenditures between such categories as food, shelter, medical expenses, debt servicing, and energy.

In addition, the Commission will consider the relevance of certain non-market activities, like household production, education, and volunteer services that affect the economic well-being of households but are not measured or valued in currently reported economic statistics. As Robert F. Kennedy famously said, some of our economic indicators measure ''everything in short, except that which makes life worthwhile.'' We need to make an effort to value more than just our gross domestic product and sales receipts. We need to better measure and understand what matters to American households.

This effort to improve how we measure what matters in our economy is very much in the Wisconsin tradition of accountable good government. It was Senator Robert LaFollette, Jr. who, in 1932, introduced a resolution requiring the U.S. Government to establish a more scientific, specific and accurate set of measures of the health of the U.S. economy. From his request, Simon Kuznets, a University of Pennsylvania economics professor, developed the first set of national accounts which form the basis for today's measure of GDP and other economic indicators. Kuznets won the 1971 Nobel Prize in Economics ''for his empirically founded interpretation of economic growth which has led to new and deepened insight into the economic and social structure and process of development''. His work was the basis for much of the New Deal reform policies. Yet Kuznets specifically acknowledged that his measures were incomplete and did not go far enough to measure what may really matter. In his 1934 report to the Senate on his compilation of statistics associated with Gross National Product he concluded: ''The welfare of a nation can . . . scarcely be inferred from a measurement of national income as [so] defined. . . .'' This bill is intended to advance these earlier efforts to make our economic statistical measures more reflective of the welfare of our families and our nation.

The cost of this commission will be fully covered by amounts already authorized and appropriated to the Bureau of Labor Statistics. I urge my colleagues to support my legislation.

By Ms. CANTWELL (for herself and Ms. COLLINS):

S. 2877. A bill to direct the Secretary of the Treasury to establish a program

to regulate the entry of fossil carbon into commerce in the United States to promote clean energy jobs and economic growth and avoid dangerous interference with the climate of the Earth, and for other purposes; to the Committee on Finance.

Ms. CANTWELL. Mr. President, I send to the desk legislation on my behalf and Senator COLLINS', the Senator from Maine, dealing with putting a market signal on carbon so we can get off of carbon and move forward on a green energy economy that will create millions of jobs in America.

I know we are still on health care so I am not going to take a lot of time right now to talk about this because we in the next several weeks and months ahead are going to have a lot of time to talk about this issue. But I do want to say for my colleagues, as we are introducing this legislation: The American people have been on a roller coaster ride with energy prices. I know the Presiding Officer knows this because she comes from the Northeast and knows what home heating oil costs have done to her State and surrounding States. I know my colleague from Maine knows this as well. That is part of her motivation in joining me in this cause, I am sure. The American public cannot sustain having oil prices wreak havoc on our economy for the next 30 years.

We know from economists that sometime in the next 5 to 30 years we will be at peak oil, and once we are at peak oil, the cost to the U.S. economy will be even more extravagant. The American people want to know what we are going to do to transition off of that and do so in a respectable way. What they are not so interested in is a proposal that would have Wall Street come up with a funding source by doing speculative trading to continue the games that have been played for the last year or 2 years on various commodities that drove the economy into the ditch.

I find it interesting that today in the newspapers coming from Copenhagen, now they have decided that up to 90 percent of all market activity in the European trading markets was related to fraudulent activity. That tells us that trading markets already existing on carbon futures have had great deals of problems with manipulation. I don't think we need to repeat that. What we want to do instead is say, we are going to make sure that consumers get a check back to help them with their energy bills. We want to say we are going to protect them from the skyrocketing prices of energy, but we are going to transition off of fossil fuels and onto new sources of energy, of biofuels, of alternatives such as wind and solar, of things such as plug-in electric vehicles, of an electricity grid that can be more efficient and a smart two-way communications system.

In the end, our economy is going to be better. We are going to create more jobs. We are going to make sure that consumers are not held hostage by future huge energy spikes. If we do that, we are going to leave to the next generation a better situation. We will leave the planet Earth in better shape. But most importantly, we are going to take the U.S. economy, struggling to move ahead, and we are going to create thousands of jobs in the short term and millions of jobs in the next several years. That is good news, to think that the United States could become a leader in energy technology, that we are not going to be as dependent upon the Chinese for battery technology of the future as we are right now on Middle East oil.

I introduce this legislation with the most respect for my colleagues, Senators BOXER and KERRY, LIEBERMAN and MCCAIN, many of my colleagues have been involved in this issue for many decades, but to work across the aisle. If health care shows us anything, we have to cut down the amount of time it takes to move these important pieces of legislation by working together in an effort to show that we do understand the needs of the American public. We have to drive down their costs, not just on health care but on fuel as well. We have to give them economic opportunity for the future. Sending this market signal is the best way to create jobs and help protect consumers for the future.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I am pleased to join my colleague from Washington State, Senator CANTWELL, in introducing what I believe to be landmark legislation, the Carbon Limits and Energy for America's Renewal, or CLEAR Act. Let me commend the Senator for her leadership on this important issue.

One of the most appealing parts of this bill is it takes a fresh look at the issues facing our country in the area of developing alternative energy, promoting energy independence, and addressing climate change and the need for more green jobs in the economy. Indeed, this bill addresses the most significant energy and environmental challenges we face. It would help to reduce our dependence on foreign oil, promote alternative energy and energy conservation, and advance the goal of energy independence for our Nation.

The cost of gas and oil imposes a great burden on many Americans, particularly those living in large rural States such as the State of Maine. High gasoline prices have a disproportionate impact on Mainers who often have no choice but to travel long distances to their jobs, grocery stores, and doctors offices. This lessens the amount of money they have to spend on other necessities.

In addition, 80 percent of Mainers heat their homes with home heating oil. That is one of the highest percentages in the Nation. The State of Maine is one of the States most dependent on foreign oil of any State in the Nation. Our Nation must work together on comprehensive long-term actions that will stabilize gas and oil prices, help to prevent energy shortages, avoid those spikes when we are held hostage to foreign oil, and achieve national energy independence. This effort will require a stronger commitment to renewable energy sources such as wind energy, as well as energy efficiency and conservation.

The development and implementation of these new approaches to environmental stewardship and energy independence will also provide a powerful stimulus to our economy and the creation of green jobs. Like my colleague, I want the United States to lead the way on green technology, not lose our edge to China, for example.

In addition to advancing these goals, the CLEAR Act is the fairest climate change approach from the perspective of consumers. It would rebate 75 percent of the proceeds generated by the cap on carbon emissions directly to citizens. That is a tremendous advantage of this bill over alternative approaches such as the cap-and-trade bill.

I also share the concerns of my colleague from Washington State about the abuses we have seen in energy and agricultural markets, when speculators are allowed to participate in the market. That is why in our bill, which imposes an upstream cap on carbon, only the producers are allowed to participate in the trading. That is a far better approach that will guard against market manipulation and excessive speculation.

In the United States alone, emissions of the primary greenhouse gas carbon dioxide have risen more than 20 percent since 1990. Clearly climate change is a daunting environmental challenge, but we must develop solutions that do not impose a heavy burden on our economy, particularly during these difficult economic times. That is why I am pleased to join as the lead cosponsor of the CLEAR Act. Climate change legislation must protect consumers and industries that could be hit with higher energy prices. We must recognize that many of our citizens are struggling to afford their monthly energy bills now and cannot afford dramatically higher prices. We also must produce legislation that would provide predictability in the price of carbon emissions so that businesses can plan, invest, and create good jobs. Climate change legislation should encourage the adoption of energy efficiency measures and the further development of renewable energy.

I am very excited about the possibilities for the State of Maine because of its immense potential to develop offshore wind energy. Estimates are that the development of 5 gigawatts of offshore wind in Maine would be enough to power more than 1 million homes for a year. It could attract $20 billion of investment to the State of Maine and create more than 15,000 green energy jobs, jobs that are desperately needed in our State. The CLEAR Act would help to achieve all of those goals.

I could not support the bill that was passed to deal with climate change by the House of Representatives. Let me read a couple of the descriptions of that bill. The New York Times described it as ''fat with compromises, carve-outs, concessions, and out-and-out gifts.'' The Washington Post in an editorial described it as having pollution credits and revenue that were ''divvied up to the advantage of politically favored polluters.''

I do not believe this bill, which is a 2,000-page monstrosity, can garner the necessary 60 votes to proceed in the Senate. The CLEAR Act, by contrast, would help to move a stalled debate forward by offering a fairer, a more efficient, and a straightforward approach.

You have only to look at our bill. It is 39 pages long compared to 2,000 pages of the House-passed bill.

My full statement goes into detail on how the bill would work. I hope my colleagues will look closely at it. But let me talk about one part. That is in the CLEAR Act, 75 percent of the carbon auction revenues would be returned to consumers as tax free rebates. They wouldn't be lost to speculation or to $½ billion of fees every year to investment firms on Wall Street. No, 75 percent of those revenues would be returned on a per capita basis to consumers. That means that 80 percent of Americans would incur no net new cost under the CLEAR Act. The average Mainer would stand to actually gain $102 per year from the CLEAR Act. I can tell you, Mainers would welcome that. It would help them winterize their homes, meet their energy bills, invest in energy conservation and efficiency, or have a little more money to get by.

By contrast, under the House-passed cap-and-trade bill, the average citizen in this country would experience a net cost increase of $175 per year. That is a big difference and a big advantage of the Cantwell-Collins approach.

What about the other 25 percent of the auction revenues? What we would propose is that those would go to a trust fund to fund energy efficiency programs and renewable energy research and development, to provide incentives for forestry and agriculture practices that sequester carbon, to encourage practices that reduce other greenhouse gases, to help energy-efficient, energy-intensive manufacturers, and to assist low-income consumers. That fund would be called the Clean Energy Reinvestment Trust, the CERT fund. It would be subject to the annual appropriations process so that Congress could adapt assistance for climate-related activities on an annual basis rather than being locked into a complicated allocation scheme that may well favor special interests.

I am excited about this bill. It offers us a way forward to a green economy. It will help create jobs. It will alleviate the burden on consumers, particularly in New England, where the Presiding Officer and I live, as well as the Northwest. It makes sense. It is a commonsense approach. I hope my colleagues will consider joining the Senator from Washington and me on this important legislation.

Again, I commend Senator CANTWELL's leadership. She has done a great deal of work to come up with this approach, and I am excited to be joining her in this effort.

To reiterate, today I am pleased to join my colleague from Washington, Senator CANTWELL, in introducing landmark legislation, the Carbon Limits and Energy for America's Renewal, or CLEAR, Act.

This bill addresses the most significant energy and environmental challenges facing our country. It would help reduce our dependence on foreign oil, promote alternative energy and energy conservation, and advance the goal of energy independence for our Nation.

The costs of gas and oil impose a great burden on many Americans, particularly those living in large, rural States like Maine. High gasoline prices have a disproportionate impact on Mainers who often have to travel long distances to their jobs, doctors' offices, and grocery stores, which lessens the amount of money they have available to spend on other necessities. Also, 80 percent of Mainers heat their homes with home heating oil, one of the highest percentages in the Nation. Our Nation must work together on comprehensive, long-term actions that will stabilize gas and oil prices, help to prevent energy shortages, and achieve national energy independence. This effort will require a stronger commitment to renewable energy sources, such as wind energy, and energy efficiency and conservation.

The development and implementation of these new approaches to environmental stewardship and energy independence will also provide a powerful stimulus for our economy and the creation of ''green'' jobs.

In addition to advancing the goal of energy independence and creating green jobs, the CLEAR Act is the fairest climate change approach for consumers. It would rebate 75 percent of the proceeds generated by the cap on carbon directly to citizens.

According to recent reports from the Intergovernmental Panel on Climate Change, increases in greenhouse gas emissions have already increased global temperatures, and likely contributed to more extreme weather events such as droughts and floods. These emissions will continue to change the climate, causing warming in most regions of the world, and likely causing more droughts, floods, and many other problems.

In the United States alone, emissions of the primary greenhouse gas, carbon dioxide, have risen more than 20 percent since 1990. Climate change is the most daunting environmental challenge we face, and we must develop reasonable solutions to reduce our carbon emissions.

I have personally observed the dramatic effects of climate change and had the opportunity to be briefed by the preeminent experts, including University of Maine professor and National Academy of Sciences member George Denton. In 2006, on a trip to Antarctica and New Zealand, for example, I saw sites in New Zealand that had been buried by massive glaciers at the beginning of the 20th century, but are now ice free. Fifty percent of the glaciers in New Zealand have melted since 1860—an event unprecedented in the last 5,000 years. It was remarkable to stand in a place where some 140 years ago, I would have been covered in tens or hundreds of feet of ice, and then to look far up the mountainside and see how distant the edge of the ice is today.

The melting is even more dramatic in the Northern Hemisphere. In the last 30 years, the Arctic has lost sea ice cover over an area ten times as large as the State of Maine, and at this rate will be ice free by 2050. In 2005 in Barrow, AK, I witnessed a melting permafrost that is causing telephone poles, planted years ago, to lean over for the first time ever.

I also learned about the potential impact of sea level rise during my trips to these regions. If the west Antarctica ice sheet were to collapse, for example, sea level would rise 15 feet, flooding many coastal cities. In its 2007 report, the IPCC found that even with just gradual melting of ice sheets, the average predicted sea level rise by 2100 will be 1.6 feet, but could be as high as 1 meter, or almost 3 feet. In Maine a 1 meter rise in sea level would cause the loss of 20,000 acres of land, include 100 acres of downtown Portland, including Commercial Street. Already in the past 94 years, a 7-inch rise in sea level has been documented in Portland.

The solutions to these problems must not impose a heavy burden on our economy, particularly during these difficult economic times. That is why I am pleased to be the lead cosponsor of the CLEAR Act.

While we must take meaningful action to respond to climate change, it must be a balanced approach. Climate change legislation must protect consumers and industries that could be hit with higher energy prices. We must recognize that many of our citizens are struggling just to pay their monthly energy bills and cannot afford dramatically higher prices. Such legislation also must provide predictability so that businesses can plan, invest, and create jobs.

Climate change legislation should encourage adoption of energy efficiency measures and the further development of renewable energy, which could spur our economy and job creation. For example, Maine has immense potential to develop offshore wind energy. Estimates are that development of 5 gigawatts of offshore wind in Maine—

enough to power more than 1 million homes for a year—could attract $20 billion of investment to the State and create more than 15,000 green energy jobs that would be sustained over 30 years.

The CLEAR Act achieves all of these goals, whereas the bill passed by the House of Representatives earlier this year has been characterized by the Boston Globe as ''providing cushions for industry;'' ''fat with compromises, carve-outs, concessions and out-and-out gifts,'' a New York Times article by John Broder, June 30, 2009; and having pollution credits and revenue that were ''divvied up to the advantage of politically favored polluters,'' from the Washington Post editorial, June 26, 2009. This House bill could not garner the necessary 60 votes in the Senate. The CLEAR Act will help to move a stalled debate forward by offering a more efficient, straightforward approach.

Let me discuss how our bill would work. The CLEAR Act places an upstream cap on carbon entering the economy. The upstream cap on carbon would capture 96 percent of all carbon dioxide emissions, 93 percent of total annual U.S. greenhouse gas emissions by weight, and 82 percent of total annual U.S. greenhouse gas emissions by global warming potential.

The initial annual carbon budget under the cap would be set based on the amount of fossil carbon likely to be consumed by the U.S. economy in 2012, the year in which the CLEAR Act regulations would begin, based on projections by the Energy Information Administration. For the first 2 years, the cap would stay at the 2012 level to give companies time to adapt to the system. Starting in 2015, the carbon budget would be reduced annually along a schedule designed to achieve nearly an 80 percent reduction in 2005 level emissions by 2050.

The cap will recognize voluntary regional efforts like the Regional Greenhouse Gas Initiative, RGGI. RGGI is a cooperative effort by 10 northeast and mid-Atlantic States to limit greenhouse gas emissions. These 10 States have capped CO_2 emissions from the power sector and will require a 10-percent reduction in these emissions by 2018.

Coal companies, oil and gas producers, and oil and gas importers would have to buy permits or ''allowances'' for the carbon in their products. They would buy the permits in a monthly auction in which those companies would be the only ones allowed to participate. One hundred percent of the allowances would be auctioned; no free allowances are provided to special interests. Thus, the CLEAR Act does not provide special favors like the House bill.

Unlike the House bill, in the CLEAR Act, only the companies directly regulated by the legislation would participate in the auction. This avoids the huge potential for market manipulation and speculation to drive up carbon prices that exists in the House bill. Financial experts estimate that under the House bill, carbon permit trading could create a $3 trillion commodity market by 2020. Do we really want to have energy consumers subsidizing Wall Street traders?

In the CLEAR Act, 75 percent of the carbon auction revenues would be returned to consumers as tax-free rebates. Nationwide, this means 80 percent of Americans would incur no net costs under the CLEAR Act. The average Mainer would stand to gain $102 per year from the CLEAR Act. By contrast, under the House-passed cap and trade bill, the average citizen would experience a net cost increase of $175 per year.

The other 25 percent of the auction revenues generated under CLEAR would go into a trust fund to fund energy efficiency programs and renewable energy research and development, to provide incentives for forestry and agriculture practices that sequester carbon, to encourage practices that reduce other greenhouse gases, to help energy-intensive manufacturers, and to assist low-income consumers. The fund, called the Clean Energy Reinvestment Trust, CERT Fund, would be subject to the annual appropriations process. This would allow Congress to adapt assistance for climate-related activities on an annual basis, rather than being locked into a complicated allocation scheme that favors special interests.

I applaud the leadership of my colleague from Washington for developing this straightforward, effective and fair climate bill. I urge all my colleagues to consider joining us on this important legislation.

By Mr. ROCKEFELLER (for himself, Mrs. HUTCHISON, Mr. KERRY, Ms. SNOWE, Mr. PRYOR, and Mr. WARNER):

S. 2879. A bill to direct the Federal Communications Commission to conduct a pilot program expanding the Lifeline Program to include broadband service, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. ROCKEFELLER. Mr. President, I rise today to introduce legislation that will enable more low-income households to receive broadband and its benefits.

Broadband has fundamentally changed the way Americans live their daily lives. It has changed how we do business, get information, find jobs, learn, communicate, and interact with Federal, State, and local governments. Over the next few years, we can only expect more innovation and more broadband applications that open doors to new opportunities and provide even more benefits to consumers.

While broadband has been more quickly deployed and adopted in predominantly urban areas, availability and adoption in rural areas has lagged behind. Low-income rural households are among the least likely to subscribe to broadband. At the same time, businesses and educational institutions, among others, have migrated many essential services and opportunities to the Internet. The result is that people without broadband, particularly in rural areas, are being left behind.

Today, 77 percent of Fortune 500 companies only accept job applications online. Seventy-eight percent of students regularly use the Internet for classroom work. Similarly, State, and local government agencies, as well as vital healthcare services, are increasingly migrating online, especially as budget cuts reduce the availability and quality of offline services.

All of this means that the children of families without broadband lose access to learning opportunities. Qualified workers lose access to jobs. Low-income Americans waste precious time—sometimes even having to take off from their jobs—in government offices, waiting for services that are otherwise available online.

This income-based digital divide is stark. Americans who earn less than $30,000 per year have a 50 percent lower rate of broadband adoption than those who earn $100,000 annually. What makes it worse is that, in some ways, low-income consumers are the ones who stand to benefit the most from affordable broadband access. Online job information and educational opportunities can provide low-income consumers with critical means to improve their lives and the lives of their children.

Like basic telephone service, broadband is quickly becoming a necessity. Consumers without access are at risk of becoming second class citizens in a growing digital world. The original Lifeline program recognized that telephone service was a critical part of everyday life and that low-income Americans needed to be connected to the world around them. What was true for telephony then is true for broadband now. That is why the Lifeline program at the FCC should be expanded to support broadband access for low-income households.

The legislation we introduce today creates a two-year pilot program to expand the FCC's Lifeline program by supporting broadband service for eligible low-income households. It also asks the FCC to provide Congress with a report on expanding the Link-Up program to assist with the costs of securing equipment, such as computers, needed to use broadband service.

We must make sure that we act now to bridge the divide that threatens to make low-income consumers second-class citizens. For this reason, I urge my colleagues to join me and support this legislation.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3164. 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 3165. Mr. BINGAMAN 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 3166. Mr. BINGAMAN 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 3167. Mr. BINGAMAN 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 3168. Mr. CASEY (for himself and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3169. Mr. CORNYN (for himself and Mr. COBURN) 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 3170. Mr. PRYOR (for himself 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 3171. Mr. PRYOR 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 3172. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3173. Mr. MERKLEY (for himself and 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 3174. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3175. Mr. SPECTER (for himself, Mr. BROWN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3176. Mr. GRASSLEY 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 3177. Mr. GRASSLEY 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 3178. Mr. GRASSLEY 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 3179. Mr. GRASSLEY 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 3180. Mr. GRASSLEY (for himself and Mr. ROBERTS) 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 3181. Mr. GRASSLEY 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 3182. Mr. GRASSLEY 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 3183. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3184. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3185. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3186. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3187. Mr. WYDEN (for himself and 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 3188. Ms. CANTWELL 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 3189. Mr. ENZI 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 3190. Mr. ENZI 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 3191. Mr. ENZI 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 3192. Mr. ENZI 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 3193. Mr. ENZI 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 3194. Mr. ENZI 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 3195. Mr. ENZI 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 3196. Mr. ENZI 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 3197. Mr. ENZI 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 3198. Mr. CORNYN (for himself and Mr. LEMIEUX) 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 3164. 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 330, strike lines 7 through 11 and inserting the following:

''individual is—

''(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

''(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

SA 3165. Mr. BINGAMAN 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 1395, strike line 11 and all that follows through ''**SEC. 778.**'' on line 15 and insert the following:

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 311 the following:

''SEC. 311A.

SA 3166. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the ability of Medicare beneficiaries to fully access available health care services during the 5-year period following enactment of this Act. Such study shall include the following:

(1) A detailed analysis regarding levels of access to health care services for different groups or populations of Medicare beneficiaries, including a breakdown—

(A) by location, including rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act), health professional shortage areas (as designated under section 332 of the Public Health Service Act), medically underserved communities (as defined in section 799B(6) of such Act), and medically underserved populations (as defined in section 330(b)(3) of such Act);

(B) by type of health care service, including physician services and primary care services; and

(C) by any other measure determined appropriate by the Comptroller General.

(2) A summary that identifies—

(A) any groups or populations of Medicare beneficiaries that lack adequate access to health care services; and

(B) any types of health care services that are not fully accessible to Medicare beneficiaries.

(b) REPORT.—

(1) INTERIM REPORT.—Not later than 30 months after the date of enactment of this Act, the Comptroller General shall prepare and submit an interim report to Congress that contains the preliminary results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) FINAL REPORT.—Not later than 60 months after the date of enactment of this Act, the Comptroller General shall prepare and submit a final report to Congress that contains the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) MEDICARE BENEFICIARY.—In this section, the term ''Medicare beneficiary'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act, enrolled under part B of such title, or both.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SA 3167. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1413 and insert the following:

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange, to a State Medicaid program under title XIX of the Social Security Act, or to a State children's health insurance program (CHIP) under title XXI of such Act, is found to be ineligible for the program to which the individual applied, the individual shall be screened for eligibility for all other potentially applicable such programs and shall be enrolled in the program for which the individual qualifies.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(D) RELEVANCE.—The forms described in subparagraphs (A) and (B) shall not require the applicant to answer any questions that are irrelevant to establishing eligibility for applicable State health subsidy programs. The Secretary shall establish procedures that avoid any need for such requirements, which shall include determining the amounts expended for medical assistance that are described in subsection (y)(1) of section 1905 of the Social Security Act (as added by section 2001(a)(3) of this Act) through the use of the post-enrollment procedures described in section 1903(u)(1)(C) of the Social Security Act.

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) notwithstanding section 1411(b), by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) is consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

(3) DETERMINATION OF ELIGIBILITY.—

(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement, provided that if such data do not establish an individual's eligibility for medical assistance under title XIX of the Social Security Act, the rules described in section 1902(e)(14)(H) of such Act shall apply to such individual.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model

agreements, and enter into agreements, for the sharing of data under this section.

(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ''applicable State health subsidy program'' means—

(1) the program under this title for the determination of eligibility for premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SA 3168. Mr. CASEY (for himself and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 466, between lines 5 and 6, insert the following:

SEC. 2305. OPTIONAL COVERAGE OF NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2006, and 2301(a)(1), is amended—

(1) in subsection (a)—

(A) in paragraph (28), by striking ''and'' at the end;

(B) by redesignating paragraph (29) as paragraph (30); and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) nurse home visitation services (as defined in subsection (z)); and''; and

(2) by inserting after subsection (y) the following new subsection:

''(z) The term 'nurse home visitation services' means voluntary home visits that are provided by trained nurses to a family with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary based upon evidence, that such services are effective in achieving 1 or more of the following:

''(1) Improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies.

''(2) Reducing the incidence of child abuse, neglect, and injury, improving family stability (including reduction in the incidence of intimate partner violence), or reducing maternal and child involvement in the criminal justice system.

''(3) Increasing economic self-sufficiency, employment advancement, school-readiness, and educational achievement, or reducing dependence on public assistance.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

(c) CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as affecting the ability of a State under title XIX or XXI of the Social Security Act to provide nurse home visitation services as part of another class of items and services falling within the definition of medical assistance or child health assistance under the respective title, or as an administrative expenditure for which payment is made under section 1903(a) or 2105(a) of such Act, respectively, on or after the date of the enactment of this Act.

SA 3169. Mr. CORNYN (for himself and Mr. COBURN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 6001.

SA 3170. Mr. PRYOR (for himself 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 828, between lines 3 and 4, insert the following:

SEC. 3130. RESTORING STATE AUTHORITY TO WAIVE THE 35-MILE RULE FOR MEDICARE CRITICAL ACCESS HOSPITAL DESIGNATIONS.

Section 1820(c)(2)(B)(i)(II) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is amended by inserting ''or on or after the date of enactment of the Patient Protection and Affordable Care Act'' after ''January 1, 2006,''.

SA 3171. Mr. PRYOR 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, between lines 20 and 21, insert the following:

SEC. 9005A. ANNUAL ROLLOVER OF HEALTH FSA BALANCES.

(a) IN GENERAL.—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as added by section 9005(a)(2), is amended—

(1) by striking all matter before ''if a benefit'' and inserting the following:

''(i) SPECIAL RULES APPLICABLE TO HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) LIMITATION ON CONTRIBUTIONS TO HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section,'', and

(2) by adding at the end the following new paragraph:

''(2) ALLOWANCE OF CARRYOVER OF UNUSED AMOUNTS IN HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(A) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan solely because under the plan or arrangement a participant is permitted access to any unused amounts attributable to salary reduction contributions under such plan or arrangement in the manner provided under subparagraph (B).

''(B) CARRYOVER OF UNUSED AMOUNTS.—A plan or arrangement may permit a participant in a health flexible spending arrangement to elect to carry over so much of the unused amounts attributable to salary reduction contributions under such plan or arrangement as of the close of any calendar year as does not exceed $1,000 to the immediately succeeding calendar year.

''(C) AMOUNTS NOT DEFERRED COMPENSATION.—No amount shall be treated as deferred compensation for purposes of this title by reason of any carryover under this paragraph.

''(D) COORDINATION WITH CONTRIBUTION LIMIT.—The maximum amount which may be contributed to a health flexible spending arrangement under paragraph (1) for any calendar year to which an unused amount is carried over under this paragraph shall be reduced by such amount.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after December 31, 2010.

SA 3172. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 18, between lines 15 and 16, insert the following:

''SEC. 2713A. COVERAGE OF CERTAIN CARE.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for wound-care supplies that are medically necessary for the treatment of epidermolysis bullosa and are administered under the direction of a physician.''.

SA 3173. Mr. MERKLEY (for himself and 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:

On page 354, between lines 2 and 3, insert the following:

(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

(i) subparagraph (A) shall be applied by substituting ''who employed an average of at least 5 full-time employees on business days during the preceeding calendar year or whose annual payroll expenses exceed $250,000 for such preceeding calendar year'' for ''who employed an average of at least 50 full-time employees on business days during the preceeding calendar year'', and

(ii) subparagraph (B) shall be applied by substituting ''5'' for ''50''.

SA 3174. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At after title IX, insert the following:

TITLE X—HEALTH CARE REFORM OVERSIGHT COMMITTEE

SEC. 10001. HEALTH CARE REFORM OVERSIGHT COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Reform Oversight Committee (referred to in this section as the ''Committee''), for the purpose of maintaining close oversight of the implementation of the requirements of this Act (including the amendments made by this Act), including with regard to the affordability criteria set forth in this Act, the impact of this Act on small businesses, and pricing trends resulting from implementation of this Act.

(b) MEMBERSHIP.—The Committee shall be composed of 12 members, selected by the President pro tempore of the Senate and the Speaker of the House of Representatives, in consultation with the majority and minority leaders of the Senate and of the House of Representatives, from among members of the public experienced in health care administration, tax policy, small business, actuarial science, health insurance plan design or sales, or a profession that would lend credibility to the work of the Committee. Not more than 3 members of the Committee may be Federal employees.

(c) CHAIRPERSON.—The Committee shall select a Chairperson from among its members.

(d) MEETINGS.—The Committee shall meet at the call of the chairperson, or as voted by 7 members, as is necessary to maintain close oversight of the implementation of the requirements of this Act (including the amendments made by this Act), to address specific problems raised by such implementation, or to address constituent concerns.

(e) QUORUM.—A quorum shall consist of a total of 7 members of the Committee, except that a total of 5 members shall be present to conduct hearings, unless such requirement that 5 members be present to conduct hearings is waived by a majority of the Committee.

(f) DUTIES OF THE COMMITTEE.—The Committee shall provide close oversight of all aspects of the requirements of this Act, including the amendments made by this Act.

(g) POWERS OF THE COMMITTEE.—

(1) HEARINGS.—The Committee may, for the purpose of carrying out this section—

(A) hold such hearings, sit and act at such times and places, take such testimony, receive such evidence, administer such oaths; and

(B) require, by subpoena or otherwise, the attendance and testimony of such witnesses and the production of such books, records, correspondence, memoranda, papers, documents, tapes, and materials as the Committee considers advisable.

(2) REPORTS AND RECOMMENDATIONS.—The Committee may issues reports and findings as it deems appropriate, including offering suggestions for legislation to improve the requirements and activities under this Act (including the amendments made by this Act).

(3) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

(A) ISSUANCE.—Subpoenas issued under paragraph (1) shall bear the signature of the Chairperson of the Committee and shall be served by any person or class of persons designated by the Chairperson for that purpose.

(B) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under paragraph (1), the United States district court for the judicial district in which the subpoenaed person resides, is served, or may be found may issue an order requiring such person to appear at any designated place to testify or to produce documentary or other evidence. Any failure to obey the order of the court may be punished by the court as a contempt that court.

(4) WITNESS ALLOWANCES AND FEES.—Section 1821 of title 28, United States Code, shall apply to witnesses requested or subpoenaed to appear at any hearing of the Committee. The per diem and mileage allowances for witnesses shall be paid from funds available to pay the expenses of the Committee.

(5) INFORMATION FROM FEDERAL AGENCIES.—The Committee may secure directly from any Federal department or agency such information as the Committee considers necessary to carry out this Act. Upon request of the Chairperson of the Committee, or of another member of the Committee representing a majority vote, the head of such department or agency shall furnish such information to the Committee.

(6) POSTAL SERVICES.—The Committee may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(7) GIFTS.—The Committee may accept, use, and dispose of gifts or donations of services or property.

(h) COMPENSATION OF MEMBERS.—

(1) IN GENERAL.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

(i) TERMINATION OF THE COMMITTEE.—The Committee shall terminate 5 years after the date of enactment of this Act.

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SA 3175. Mr. SPECTER (for himself, Mr. BROWN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS FROM MANUFACTURER'S AVERAGE SALES PRICE FOR PAYMENTS FOR DRUGS AND BIOLOGICALS UNDER MEDICARE PART B.

Section 1847A(c)(3) of the Social Security Act (42 U.S.C. 1395w–3a(c)(3)) is amended—

(1) in the first sentence, by inserting after ''prompt pay discounts'' the following: ''(other than, for drugs and biologicals that are sold on or after January 1, 2011, and before January 1, 2016, customary prompt pay discounts extended to wholesalers, but only to the extent such discounts do not exceed 2 percent of the wholesale acquisition cost)''; and

(2) in the second sentence, by inserting after ''other price concessions'' the following: ''(other than, for drugs and biologicals that are sold on or after January 1, 2011, and before January 1, 2016, customary prompt pay discounts extended to wholesalers, but only to the extent such discounts do not exceed 2 percent of the wholesale acquisition cost)''.

SA 3176. Mr. GRASSLEY 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 334, between lines 18 and 19, insert the following:

''(E) SPECIAL RULE FOR INDIVIDUALS BETWEEN THE AGES OF 55 AND 64.—

''(i) IN GENERAL.—In the case of an applicable individual who has attained the age of 55 but has not attained the age of 65 before the beginning of a calendar year, this paragraph shall be applied to such individual for months during such calendar year by substituting '5 percent' for '8 percent' in subparagraphs (A) and (D).

''(ii) USE OF INCREASED FEDERAL FUNDS.—

''(I) IN GENERAL.—The amount available for any calendar year for expenditure under the early retiree reinsurance program under section 1102 of the Patient Protection and Affordable Care Act shall be increased by the amount the Secretary of Health and Human Services estimates under subclause (II) for the calendar year. Notwithstanding section 1102(a)(1) of such Act, amounts made available under this subclause for any calendar year after 2014 may be used to make payments under such reinsurance program.

''(II) ESTIMATES.—The Secretary of Health and Human Services, in consultation with the Secretary, shall estimate for each calendar year after 2013 the net increase (if any) in Federal revenues, and the net decrease (if any) in Federal outlays, by reason of the application of clause (i). The sum of such amounts (expressed as a positive number)

shall be the amount taken into account under subclause (I). The Secretary shall adjust the estimate for any calendar year to correct any errors in an estimate for any preceding calendar year.

SA 3177. Mr. GRASSLEY 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 336, between lines 16 and 17, insert the following:

''(6) COLLEGE STUDENTS.—

''(A) IN GENERAL.—Any applicable individual for any month which occurs within an academic period during which the individual is a student (whether full-time or part-time) who meets the requirements of section 484(a)(1) of the Higher Education Act of 1965 (20 U.S.C. 1091(a)(1)) at an institution of higher education (including a community college or trade school) described in such section. For purposes of the preceding sentence, any month between 2 consecutive academic periods shall be treated as occurring during an academic period.

''(B) USE OF INCREASED FEDERAL FUNDS.—

''(i) IN GENERAL.—The amount available for any calendar year for expenditure under the reinsurance program under section 1341 of the Patient Protection and Affordable Care Act shall be increased by the amount the Secretary of Health and Human Services estimates under clause (11) for the calendar year. Notwithstanding section 1341(b)(4) of such Act, amounts made available under this subclause for any calendar year after 2018 may be used to make payments under any reinsurance program of a State in the individual market in effect during such calendar year.

''(ii) ESTIMATES.—The Secretary of Health and Human Services, in consultation with the Secretary, shall estimate for each calendar year after 2013 the net increase (if any) in Federal revenues, and the net decrease (if any) in Federal outlays, by reason of the application of subparagraph (A). The sum of such amounts (expressed as a positive number) shall be the amount taken into account under clause (i). The Secretary shall adjust the estimate for any calendar year to correct any errors in an estimate for any preceding calendar year.

SA 3178. Mr. GRASSLEY 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 156, beginning with line 4, strike all through page 157, line 7, and insert the following:

(D) PRESIDENT, VICE PRESIDENT, MEMBERS OF CONGRESS, POLITICAL APPOINTEES, AND CONGRESSIONAL STAFF IN THE EXCHANGE.—

(i) IN GENERAL.—Notwithstanding chapter 89 of title 5, United States Code, or any provision of this title—

(I) the President, Vice President, each Member of Congress, each political appointee, and each Congressional employee shall be treated as a qualified individual entitled to the right under this paragraph to enroll in a qualified health plan in the individual market offered through an Exchange in the State in which the individual resides; and

(II) any employer contribution under such chapter on behalf of the President, Vice President, any Member of Congress, any political appointee, and any Congressional employee may be paid only to the issuer of a qualified health plan in which the individual enrolled in through such Exchange and not to the issuer of a plan offered through the Federal employees health benefit program under such chapter.

(ii) PAYMENTS BY FEDERAL GOVERNMENT.—The Secretary, in consultation with the Director of the Office of Personnel Management, shall establish procedures under which—

(I) the employer contributions under such chapter on behalf of the President, Vice President, and each political appointee are determined and actuarially adjusted for age; and

(II) the employer contributions may be made directly to an Exchange for payment to an issuer.

(iii) POLITICAL APPOINTEE.—In this subparagraph, the term ''political appointee'' means any individual who—

(I) is employed in a position described under sections 5312 through 5316 of title 5, United States Code, (relating to the Executive Schedule);

(II) is a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of section 3132(a) of title 5, United States Code; or

(III) is employed in a position in the executive branch of the Government of a confidential or policy-determining character under schedule C of subpart C of part 213 of title 5 of the Code of Federal Regulations.

(iv) CONGRESSIONAL EMPLOYEE.—In this subparagraph, the term ''Congressional employee'' means an employee whose pay is disbursed by the Secretary of the Senate or the Clerk of the House of Representatives.

SA 3179. Mr. GRASSLEY 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 334, between lines 18 and 19, insert the following:

''(E) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 30.—

''(i) IN GENERAL.—In the case of an applicable individual who has not attained age 30 before the beginning of a calendar year, this paragraph shall be applied to such individual for months during such calendar year by substituting '5 percent' for '8 percent' in subparagraphs (A) and (D).

''(ii) USE OF INCREASED FEDERAL FUNDS.—

''(I) IN GENERAL.—The amount available for any calendar year for expenditure under the reinsurance program under section 1341 of the Patient Protection and Affordable Care Act shall be increased by the amount the Secretary of Health and Human Services estimates under subclause (II) for the calendar year. Notwithstanding section 1341(b)(4) of such Act, amounts made available under this subclause for any calendar year after 2018 may be used to make payments under any reinsurance program of a State in the individual market in effect during such calendar year.

''(II) ESTIMATES.—The Secretary of Health and Human Services, in consultation with the Secretary, shall estimate for each calendar year after 2013 the net increase (if any) in Federal revenues, and the net decrease (if any) in Federal outlays, by reason of the application of clause (i). The sum of such amounts (expressed as a positive number) shall be the amount taken into account under subclause (I). The Secretary shall adjust the estimate for any calendar year to correct any errors in an estimate for any preceding calendar year.

SA 3180. Mr. GRASSLEY (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1053, between lines 2 and 3, insert the following:

SEC. 3403A. PROTECTING SENIORS FROM HIGHER PREMIUMS, REDUCED BENEFITS, AND RATIONING OF LIFE-SAVING CARE UNDER MEDICARE PARTS C AND D.

Section 1899A(c)(2)(A) of the Social Security Act, as added by section 3403, is amended—

(1) in clause (ii), by striking ''under section 1818, 1818A, or 1839''; and

(2) by striking clause (iv).

SA 3181. Mr. GRASSLEY 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 909, strike line 21 and all that follows through page 910, line 19.

SA 3182. Mr. GRASSLEY 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—ENSURING THAT SAVINGS FROM MEDICAL CARE ACCESS PROTECTION ARE USED TO REDUCE THE COVERAGE GAP UNDER MEDICARE PART D

Subtitle A—Reducing the Coverage Gap Under Medicare Part D

SEC. 10001. REDUCING THE COVERAGE GAP.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)), as amended by section 3315, is further amended—

(1) in paragraph (3)(A), by striking ''and (7)'' and inserting '', (7), and (8)'';

(2) in paragraph (7), by striking subparagraph (C); and

(3) by adding at the end the following new paragraph:

''(8) INCREASE IN INITIAL COVERAGE LIMIT IN SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2011, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by an amount which the Chief Actuary of the Centers for Medicare & Medicaid Services determines is equal to the estimated amount of savings during the plan year as a result of the provisions of the Medical Care Access Protection Act of 2009.

''(B) CONSIDERATIONS.—In determining the amount of the increase under subparagraph (A) for a plan year, the Secretary shall take into account—

''(i) any increase under such paragraph during the preceding year or years; and

''(ii) any estimated increase in utilization as a result of the application of this paragraph.

''(C) APPLICATION.—The provisions of subparagraph (B) of paragraph (7) shall apply to the application of subparagraph (A) of this subparagraph in the same manner as such provisions apply to the application of subparagraph (A) of paragraph (7).''.

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.

SA 3183. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTING MIDDLE CLASS FAMILIES FROM TAX INCREASES.

It is the sense of the Senate that the Senate should reject any procedural maneuver that would raise taxes on middle class families, such as a motion to commit the pending legislation to the Committee on Finance, which is designed to kill legislation that provides tax cuts for American workers and families, including the affordability tax credit and the small business tax credit.

SA 3184. 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:

At the appropriate place in title IX, insert the following:

Subtitle—Expansion of Adoption Credit and Adoption Assistance Programs

SEC. __01. EXPANSION OF ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

(a) INCREASE IN DOLLAR LIMITATION.—

(1) ADOPTION CREDIT.—

(A) IN GENERAL.—Paragraph (1) of section 23(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$15,000''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (3) of section 23(a) of such Code (relating to $10,000 credit for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$15,000'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$15,000''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (h) of section 23 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(h) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2009, each of the dollar amounts in subsections (a)(3) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A)(i) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(2) ADOPTION ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—Paragraph (1) of section 137(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$15,000''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (2) of section 137(a) of such Code (relating to $10,000 exclusion for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$15,000'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$15,000''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (f) of section 137 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(f) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2009, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(b) CREDIT MADE REFUNDABLE.—

(1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue Code of 1986 is amended—

(A) by redesignating section 23, as amended by subsection (a), as section 36B, and

(B) by moving section 36B (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(2) CONFORMING AMENDMENTS.—

(A) Section 24(b)(3)(B) of such Code is amended by striking ''23,''.

(B) Section 25(e)(1)(C) of such Code is amended by striking ''23,'' both places it appears.

(C) Section 25A(i)(5)(B) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(D) Section 25B(g)(2) of such Code is amended by striking ''23,''.

(E) Section 26(a)(1) of such Code is amended by striking ''23,''.

(F) Section 30(c)(2)(B)(ii) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(G) Section 30B(g)(2)(B)(ii) of such Code is amended by striking ''23,''.

(H) Section 30D(c)(2)(B)(ii) of such Code is amended by striking ''sections 23 and'' and inserting ''section''.

(I) Section 36B of such Code, as so redesignated, is amended—

(i) by striking paragraph (4) of subsection (b), and

(ii) by striking subsection (c).

(J) Section 137 of such Code is amended—

(i) by striking ''section 23(d)'' in subsection (d) and inserting ''section 36B(d)'', and

(ii) by striking ''section 23'' in subsection (e) and inserting ''section 36B''.

(K) Section 904(i) of such Code is amended by striking ''23,''.

(L) Section 1016(a)(26) is amended by striking ''23(g)'' and inserting ''36B(g)''.

(M) Section 1400C(d) of such Code is amended by striking ''23,''.

(N) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code of 1986 is amended by striking the item relating to section 23.

(O) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36B,'' after ''36A,''.

(P) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

''Sec. 36B. Adoption expenses.''.

(c) EXTENSION OF CREDIT AND ADOPTION ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986, as redesignated by subsection (b), is amended by adding at the end the following new subsection:

''(i) TERMINATION.—This section shall not apply to expenses paid or incurred in taxable years beginning after December 31, 2014.''.

(2) IN GENERAL.—Section 137 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) TERMINATION.—This section shall not apply to expenses paid or incurred in taxable years beginning after December 31, 2014.''.

(3) SUNSET FOR MODIFICATIONS MADE BY EGTRRA TO ADOPTION CREDIT REMOVED.—Title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 shall not apply to the amendments made by section 202 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3185. Mr. BROWN submitted an amendment intended to be proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 553, between lines 14 and 15, insert the following:

SEC. 2721. INCREASED PAYMENTS FOR PEDIATRIC CARE UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

''(C) payment for pediatric care services (as defined in subsection (hh)(1)) furnished by physicians (as defined in section 1861(r)) (or for services furnished by other health care professionals that would be pediatric care services under such subsection if furnished by a physician) at a rate not less than 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services under part B of title XVIII (or, if there is no payment rate for such services under part B of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such adjusted payment rate for such services furnished in 2011, and 100 percent of such adjusted payment rate for such services furnished in 2012 and each subsequent year;''; and

(B) by adding at the end the following new subsection:

''(hh) INCREASED PAYMENT FOR PEDIATRIC CARE.—For purposes of subsection (a)(13)(C):

''(1) PEDIATRIC CARE SERVICES DEFINED.—The term 'pediatric care services' means evaluation and management services, without regard to the specialty of the physician or hospital furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary) and that are furnished to an individual who is enrolled in the State plan under this title who has not attained age 19. Such term includes procedure codes established by the Secretary, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, for services furnished under State plans under this title to individuals who have not attained age 19 and for which there is not an a procedure code (or a procedure code that the Secretary, in consultation with such Commission, determines is comparable) established under the Healthcare Common Procedure Coding System.

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PEDIATRIC CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of pediatric care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods beginning with 2010) with respect to amounts described in subsection (cc)''; and

(2) by adding at the end the following new subsection:

''(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of the date of enactment of the Patient Protection and Affordable Care Act.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SA 3186. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 729, strike line 21 and all that follows through line 13 on page 730, and insert the following:

''(xv) Promoting—

''(I) improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

''(aa) developing, documenting, and disseminating best practices and proven care methods;

''(bb) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

''(cc) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

''(II) improved quality and reduced cost by developing a similarly focused collaborative of pediatric providers and institutions through the Medicaid and CHIP programs.''.

SA 3187. Mr. WYDEN (for himself and 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 828, between lines 3 and 4, insert the following:

SEC. 3130. MEDICARE CRITICAL ACCESS HOSPITAL PROVISIONS.

(a) FLEXIBILITY IN THE MANNER IN WHICH BEDS ARE COUNTED FOR PURPOSES OF DETERMINING WHETHER A HOSPITAL MAY BE DESIGNATED AS A CRITICAL ACCESS HOSPITAL UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1820(c)(2)(B) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)) is amended—

(A) in clause (iii), by inserting ''(or 20, as determined on an annual, average basis)'' after ''25''; and

(B) by adding at the end the following flush sentence:

''In determining the number of beds for purposes of clause (iii), only beds that are occupied shall be counted.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

(b) CRITICAL ACCESS HOSPITAL INPATIENT BED LIMITATION EXEMPTION FOR BEDS PROVIDED TO CERTAIN VETERANS.—

(1) IN GENERAL.—Section 1820(c) of the Social Security Act (42 U.S.C. 1395i–4(c)) is amended by adding at the end the following new paragraph:

''(3) EXEMPTION FROM BED LIMITATION.—For purposes of this section, no acute care inpatient bed shall be counted against any numerical limitation specified under this section for such a bed (or for inpatient bed days with respect to such a bed) if the bed is provided for an individual who is a veteran and the Department of Veterans Affairs referred the individual for care in the hospital or is coordinating such care with other care being provided by such Department.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act

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SA 3188. Ms. CANTWELL submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

SEC. _____. TREATMENT OF HRAS.

For purposes of the provisions of, and amendments made by, this Act, and the provisions of any other law, funds from a health reimbursement arrangement used in whole or in part by an individual to purchase an individual or family health benefits plan shall not be considered or construed as an employer contribution and such individual or family plan shall not be considered or construed as a group health benefits plan.

SA 3189. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1053, between lines 2 and 3, insert the following:

SEC. 3404. AUTHORITY TO VARY THE AMOUNT OF THE MEDICARE PART B PREMIUM FOR NEW BENEFICIARIES THAT SMOKE AND BENEFICIARIES THAT MAKE HEALTHY CHOICES.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j) AUTHORITY TO VARY THE AMOUNT OF THE PREMIUM FOR BENEFICIARIES THAT SMOKE AND BENEFICIARIES THAT MAKE HEALTHY CHOICES.—With respect to the monthly premium amount for individuals who enroll under this part after the date of the enactment of the Patient Protection and Affordable Care Act, the Secretary shall vary the amount of such premium for such an individual if the individual smokes or makes healthy choices to improve health outcomes (as defined by the Secretary).''.

SA 3190. Mr. ENZI 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 CERTAIN INDIVIDUALS ELIGIBLE FOR MEDICAID.—If a taxpayer is an individual described in section 1902(k)(3) of the Social Security Act who elects, in accordance with procedures established by a State under that section, to enroll in a qualified health plan and whose household income does not exceed 100 percent of an amount equal to the poverty line for a family of the size involved, 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 404, between lines 13 and 14, insert the following:

''(3) The State shall establish procedures to ensure that any individual eligible for medical assistance under the State plan or under a waiver of the plan (under any subclause of subsection (a)(10)(A) or otherwise) who is not elderly or disabled may elect to enroll in a qualified health plan through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State plan under this title or a waiver of the plan. An individual making such an election shall waive being provided with medical assistance under the State plan or waiver while enrolled in the qualified health plan. In the case of an individual who is a child, the child's parent may make such an election on behalf of the child.

SA 3191. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

SEC. 4403. TERMINATION OF PROGRAMS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), the Secretary of Health and Human Services shall terminate a program established under this title if the Secretary of Health and Human Services determines that such program has not reduced health care costs for the Federal government and beneficiaries under such program.

SA 3192. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 356, between lines 19 and 20, insert the following:

''(f) LIMITATION.—If in any calendar year the national unemployment rate (as determined by the Bureau of Labor Statistics) exceeds 6 percent, then, notwithstanding any other provision of law, this section shall not apply for the remainder of such calendar year.''.

SA 3193. Mr. ENZI 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 1142, strike lines 8 through 16 and insert the following:

(c) USE OF FUND.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the Secretary shall allocate amounts in the Fund to the high risk pool program under section 1101 and the reinsurance program for individual and small group markets in each State under section 1341, in order to lower health care premiums for Americans.

SA 3194. Mr. ENZI 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 E of title IV, insert the following:

SEC. 4403. PROHIBITION ON THE USE OF FUNDS FOR THE CONSTRUCTION OF SIDEWALKS, PLAYGROUNDS, OR JUNGLE GYMS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no funds appropriated under this Act (or an amendment made by this Act) shall be allocated to pay for the construction of sidewalks, playgrounds, or jungle gyms.

SA 3195. Mr. ENZI 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.—If a health 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—

(A) such plan 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;

(B) no requirement imposed by any provision of, or any amendment made by, this Act shall apply with respect to the plan or issuer thereof.

SA 3196. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 54, between lines 19 and 20, insert the following:

(g) USE OF FUND.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the Secretary shall allocate amounts appropriated under subsection (e) to the high risk pool program under section 1101 and the reinsurance program for individual and small group markets in each State under section 1341, in order to lower health care premiums for Americans.

SA 3197. Mr. ENZI 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 the matter proposed to be inserted and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Health Plans Act of 2009''.

TITLE I—ENHANCED MARKETPLACE POOLS

SEC. 101. RULES GOVERNING ENHANCED MARKETPLACE POOLS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ENHANCED MARKETPLACE POOLS

"SEC. 801. SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

''(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary, not later than 1 year after the date of enactment of this part, shall promulgate regulations that apply the rules and standards of this part, as necessary, to circumstances in which a pooling entity other (hereinafter 'Alternative Market Pooling Organizations') is not made up principally of employers and their employees, or not a professional organization or such small business health plan entity identified in section 801.

''(b) ADAPTION OF STANDARDS.—In developing and promulgating regulations pursuant to subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, small business health plans, small and large employers, large and small insurance issuers, consumer representatives, and state insurance commissioners, shall—

''(1) adapt the standards of this part, to the maximum degree practicable, to assure balanced and comparable oversight standards for both small business health plans and alternative market pooling organizations;

''(2) permit the participation as alternative market pooling organizations unions, churches and other faith-based organizations, or other organizations composed of individuals and groups which may have little or no association with employment, provided however, that such alternative market pooling organizations meet, and continue meeting on an ongoing basis, to satisfy standards, rules, and requirements materially equivalent to those set forth in this part with respect to small business health plans;

''(3) conduct periodic verification of such compliance by alternative market pooling organizations, in consultation with the Secretary of Health and Human Services and the National Association of Insurance Commissioners, except that such periodic verification shall not materially impede market entry or participation as pooling entities comparable to that of small business health plans;

''(4) assure that consistent, clear, and regularly monitored standards are applied with respect to alternative market pooling organizations to avert material risk-selection within or among the composition of such organizations;

''(5) the expedited and deemed certification procedures provided in section 805(d) shall not apply to alternative market pooling organizations until sooner of the promulgation of regulations under this subsection or the expiration of one year following enactment of this Act; and

''(6) make such other appropriate adjustments to the requirements of this part as the Secretary may reasonably deem appropriate to fit the circumstances of an individual alternative market pooling organization or category of such organization, including but not limited to the application of the membership payment requirements of section 801(b)(2) to alternative market pooling organizations composed primarily of church- or faith-based membership.

"SEC. 803. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

"SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to a small business health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to a small business health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust agreement has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

''(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Small Business Health Plans Act of 2009.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers.

''(c) TREATMENT OF FRANCHISES.—In the case of a group health plan which is established and maintained by a franchiser for a franchisor or for its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchisor were deemed to be the sponsor referred to in section 801(b) and each franchisee were deemed to be a member (of the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the

meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

"SEC. 805. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the dependents of individuals described in subparagraph (A).

''(b) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(c) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to a small business health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

''(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged, subject to subparagraph (B) and the terms of this title.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Small Business Health Plans Act of 2009.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Small Business Health Plans Act of 2009.

''(c) DOMICILE AND NON-DOMICILE STATES.—

''(1) DOMICILE STATE.—Coverage shall be issued to a small business health plan in the State in which the sponsor's principal place of business is located.

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Small Business Health Plans Act of 2009), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Small Business Health Plans Act of 2009)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

''(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in

each State in which the small business health plans operate.

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

''SEC. 809. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

''The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this part to accommodate with minimum disruption such changes to State or Federal law provided in this part and the (and the amendments made by such Act) or in regulations issued thereto.

''SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)–1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of a small business health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007) (concerning health plan rating and benefits) are met.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Alternative market pooling organizations.
''803. Certification of small business health plans.
''804. Requirements relating to sponsors and boards of trustees.
''805. Participation and coverage requirements.
''806. Other requirements relating to plan documents, contribution rates, and benefit options.
''807. Requirements for application and related requirements.
''808. Notice requirements for voluntary termination.
''809. Implementation and application authority by Secretary.
''810. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 6 months after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which has control over the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—MARKET RELIEF

SEC. 301. MARKET RELIEF.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''SEC. 2902. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

''The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this title to accommodate with minimum disruption such changes to State or Federal law provided in this title and the (and the amendments made by such Act) or in regulations issued thereto.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term 'Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

''(8) NONADOPTING STATE.—The term 'non-adopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(11) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

''(B) TOTAL VARIATION LIMIT.—The term 'total variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 2912(a)(1)).

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

''(A) COMPOSITE VARIATION LIMIT.—The composite variation limit shall not be less than 3:1.

''(B) TOTAL VARIATION LIMIT.—The total variation limit shall not be less than 5:1.

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

''(2) MODEL SMALL GROUP RATING RULES.—The following apply to an eligible insurer in a non-adopting State:

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

''(iv) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Small Business Health Plans Act of 2009 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Small Business Health Plans Act of 2009.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle)—

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted a law providing that small group, individual, and large group health insurers in such State may offer and sell products in accordance with the List of Required Benefits and the Terms of Application as provided for in section 2922(b).

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the List of Required Benefits and Terms of Application in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other applicable State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the List of Required Benefits and Terms of Application, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the List of Required Benefits and a description of the Terms of Application, including a description of the benefits to be provided, and that adherence to such standards is included as a term of such contract.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group, individual, or large group health insurance markets, including with respect to small business health plans, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(4) LIST OF REQUIRED BENEFITS.—The term 'List of Required Benefits' means the List issued under section 2922(a).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(7) STATE PROVIDER FREEDOM OF CHOICE LAW.—The term 'State Provider Freedom of Choice Law' means a State law requiring that a health insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law.

''(8) TERMS OF APPLICATION.—The term 'Terms of Application' means terms provided under section 2922(a).

''SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group, individual, and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through small business health plans, the List of Required Benefits applicable to the small group market shall apply.

''(b) TERMS OF APPLICATION.—

''(1) STATE WITH MANDATES.—With respect to a State that has a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required

Benefits under subsection (a), such State mandate shall, subject to paragraph (3) (concerning uniform application), apply to a coverage plan or plan in, as applicable, the small group, individual, or large group market or through a small business health plan in such State.

''(2) STATES WITHOUT MANDATES.—With respect to a State that does not have a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such mandate shall not apply, as applicable, to a coverage plan or plan in the small group, individual, or large group market or through a small business health plan in such State.

''(3) UNIFORM APPLICATION OF LAWS.—

''(A) IN GENERAL.—With respect to a State described in paragraph (1), in applying a covered benefit, service, or category of provider mandate that is on the List of Required Benefits under subsection (a) the State shall permit a coverage plan or plan offered in the small group, individual, or large group market or through a small business health plan in such State to apply such benefit, service, or category of provider coverage in a manner consistent with the manner in which such coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code (as determined by the Secretary in consultation with the Director of the Office of Personnel Management), and consistent with the Publication of Benefit Applications under subsection (c). In the event a covered benefit, service, or category of provider appearing in the List of Required Benefits is not offered in one of the three most heavily subscribed national health plans offered under the Federal Employees Health Benefits Program, such covered benefit, service, or category of provider requirement shall be applied in a manner consistent with the manner in which such coverage is offered in the remaining most heavily subscribed plan of the remaining Federal Employees Health Benefits Program plans, as determined by the Secretary, in consultation with the Director of the Office of Personnel Management.

''(B) EXCEPTION REGARDING STATE PROVIDER FREEDOM OF CHOICE LAWS.—Notwithstanding subparagraph (A), in the event a category of provider mandate is included in the List of Covered Benefits, any State Provider Freedom of Choice Law (as defined in section 2921(7)) that is in effect in any State in which such category of provider mandate is in effect shall not be preempted, with respect to that category of provider, by this part.

''(c) PUBLICATION OF BENEFIT APPLICATIONS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary, in consultation with the Director of the Office of Personnel Management, shall publish in the Federal Register a description of such covered benefits, services, and categories of providers covered in that calendar year by each of the three most heavily subscribed nationally available Federal Employee Health Benefits Plan options which are also included on the List of Required Benefits.

''(d) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''(e) UPDATING OF LIST OF REQUIRED BENEFITS.—Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as such laws—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO BENEFITS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State mandates regarding covered benefits, services, or categories of providers that would otherwise apply to eligible insurers.

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS HARMONIZATION.

Title XXIX of the Public Health Service Act (as added by section 201) is amended by adding at the end the following:

''Subtitle B—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with

the harmonized standards published pursuant to section 2933(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2933(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2933(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers 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.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

''(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

''(x) Rationale and protocols to be met before a full examination is conducted.

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding

the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the Benefit Choice Standards pursuant to section 2922(a).

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

''(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

''(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) APPLICATION AND EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall apply and become effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards applied under this section on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified under this section on the Internet website of the Department of Health and Human Services.

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle and applied as provided for in section 2933(d)(3), shall supersede any and all State laws of a nonadopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this subtitle.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of any benefits below the deductible levels set for any health savings account-qualified health plan pursuant to section 223 of the Internal Revenue Code of 1986.''.

SA 3198. Mr. CORNYN (for himself and Mr. LEMIEUX) 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 all after the first word and insert the following:

1. SHORT TITLE.

This Act may be cited as the ''Seniors and Taxpayers Obligation Protection Act of 2009''.

SEC. 2. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED TO IDENTIFY MEDICARE BENEFICIARIES UNDER THE MEDICARE PROGRAM.

(a) PROCEDURES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, in order to protect beneficiaries from identity theft, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual's social security account number is not used.

(2) MAINTAINING EXISTING HICN STRUCTURE.—In order to minimize the impact of the change under paragraph (1) on systems that communicate with Medicare beneficiary eligibility systems, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) PROTECTION AGAINST FRAUD.—The procedures under paragraph (1) shall provide for a process for changing the Medicare beneficiary identifier for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(4) PHASE-IN AUTHORITY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary may phase in the change under paragraph (1) in such manner as the Secretary determines appropriate.

(B) LIMIT.—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) NEWLY ENTITLED AND ENROLLED INDIVIDUALS.—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(b) EDUCATION AND OUTREACH.—The Secretary shall establish a program of education and outreach for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)), and suppliers (as defined in subsection (d) of such section) on the change under paragraph (1).

(c) DATA MATCHING.—

(1) ACCESS TO CERTAIN INFORMATION.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

''(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary—

''(i) enter into an agreement with the Secretary for the purpose of matching data in the system of records of the Commissioner with data in the system of records of the Secretary, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met, in order to determine—

''(I) whether a beneficiary under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible for benefits under such program; and

''(II) whether a provider of services or a supplier under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such program; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed and procedures to permit the Secretary to use such information for the purpose described in clause (i).

''(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

''(C) Information provided pursuant to an agreement under this paragraph shall include information regarding whether—

''(i) the name (including the first name and any family name or surname), the date of birth (including the month, day, and year), and social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and

''(ii) such individual is shown on the records of the Commissioner as being deceased.''.

(2) INVESTIGATION BASED ON CERTAIN INFORMATION.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. ACCESS TO CERTAIN DATA AND INVESTIGATION OF CLAIMS INVOLVING INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.

''(a) DATA AGREEMENT.—The Secretary shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

''(b) INVESTIGATION OF CLAIMS INVOLVING CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.—

''(1) IN GENERAL.—The Secretary shall, in the case where a provider of services or a supplier under the program under title XVIII, XIX, or XXI submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information provided pursuant to such agreement, is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, conduct an investigation with respect to the provider of services or supplier. If the Secretary determines further action is appropriate, the Secretary shall refer the investigation to the Inspector General of the Department of Health and Human Services.

''(2) ASSESSMENT OF IMPLEMENTATION AND EFFECTIVENESS BY THE OIG.—The Inspector General of the Department of Health and Human Services shall test the implementation of the provisions of this section (including the implementation of the agreement under section 205(r)(9)) and conduct such period assessments of such implementation as the Inspector General determines necessary to determine the effectiveness of such implementation.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 3. MONTHLY VERIFICATION OF ACCURACY OF CLAIMS FOR PAYMENT FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(7) The monthly verification of the accuracy of claims for payment for physicians' services under the system under subsection (i).''; and

(2) by adding at the end the following new subsection:

''(i) MONTHLY VERIFICATION OF ACCURACY OF CLAIMS FOR PAYMENT FOR PHYSICIANS' SERVICES.—

''(1) SYSTEM.—

''(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary shall establish and implement a system to verify (electronically or otherwise, taking into consideration the administrative burden of such verification on physicians and group practices) on a monthly basis that the claims for payment under part B for physicians' services furnished in high risk areas are—

''(i) for physicians' services actually furnished by the physician or the physician's group practice; and

''(ii) otherwise accurate.

''(B) NO DETERMINATION OF MEDICAL NECESSITY.—In no case shall any verification conducted under the system established under subparagraph (A) include a determination of the medical necessity of the physicians' service.

''(2) VERIFICATION.—Under the system, the Secretary, at the end of each month, shall provide the physician or the group practice with a detailed list of such claims for payment that were submitted during the month in order for the physician or the group practice to review and verify the list. In providing the detailed list, the Secretary shall use the provider number of the physician or the group practice.

''(3) AUDITS.—The Secretary shall conduct audits of the review and verification by physicians and group practices of the detailed list provided under paragraph (2). Such audits shall assess whether the physician or group practice conducted such review and verification in a fraudulent manner. In the case where the Secretary determines such review and verification was conducted in a fraudulent manner, the Secretary shall recoup any payments resulting from the fraudulent review and verification and impose a civil money penalty in an amount determined appropriate by the Secretary on the physician or group practice who conducted the fraudulent review and verification. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(4) HIGH RISK AREAS DEFINED.—In this subsection, the term 'high risk area' means a county designated as a high risk area under subsection (j)(1).

''(5) REPORT BY THE SECRETARY.—Not later than 1 year after implementation of the system established under paragraph (1), the Secretary shall submit a report to Congress on the progress of such implementation. Such report shall include recommendations—

''(A) on how to improve such implementation, including whether the system should be expanded to include verification of claims for payment under part B for physicians' services furnished in additional areas; and

''(B) for such legislation and administrative action as the Secretary determines appropriate.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 4. DETECTION OF MEDICARE FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd), as amended by section 3, is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(8) Implementation of fraud and abuse detection methods under subsection (j).'';

(2) in subsection (c), by adding at the end of the flush matter following paragraph (4), the following new sentence ''In the case of an activity described in subsection (b)(8), an entity shall only be eligible to enter into a contract under the Program to carry out the activity if the entity is selected through a competitive bidding process in accordance with subsection (j)(3).''; and

(3) by adding at the end the following new subsection:

''(j) DETECTION OF MEDICARE FRAUD AND ABUSE.—

''(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY COUNTIES MOST VULNERABLE TO FRAUD.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall establish a system to identify the 50 counties most vulnerable to fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title. The Secretary shall designate the counties identified under the preceding sentence as 'high risk areas'.

''(2) FRAUD AND ABUSE DETECTION.—

''(A) INITIAL IMPLEMENTATION.—The Secretary shall establish procedures for the implementation of fraud and abuse detection methods under this title with respect to items and services furnished by such providers of services and suppliers in high risk areas designated under paragraph (1) (and, beginning not later than 18 months after the date of enactment of this subsection, with respect to items and services furnished by such providers of services and suppliers in areas not so designated) including the following:

''(i) In the case of a new applicant to be a supplier, a background check, a pre-enrollment site visit, and random unannounced site visits after enrollment.

''(ii) Not less than 5 years after the date of enactment of this subsection, in the case of a supplier who is not a new applicant, re-enrollment under this title, including a background check and a site-visit as part of the application process for such re-enrollment, and random unannounced site visits after such re-enrollment.

''(iii) Data analysis to establish prepayment claim edits designed to target the claims for payment under this title for such items and services that are most likely to be fraudulent.

''(iv) Prepayment benefit integrity reviews for claims for payment under this title for such items and services that are suspended as a result of such edits.

''(B) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under subparagraph (A) (including, in the case of a supplier, the requirement of a background check) participate in the program under this title.

''(C) BACKGROUND CHECKS.—The Secretary shall determine the extent of the background check conducted under subparagraph (A), including whether—

''(i) a fingerprint check is necessary;

''(ii) a background check shall be conducted with respect to additional employees, board members, contractors or other interested parties of the supplier; and

''(iii) any additional national background checks regarding exclusion from participation in Federal programs (such as the program under this title, title XIX, or title XXI), adverse actions taken by State licensing boards, bankruptcies, outstanding taxes, or other indications identified by the Inspector General of the Department of Health and Human Services are necessary.

''(D) EXPANDED IMPLEMENTATION.—Not later than 24 months after the date of enactment of this subsection, the Secretary shall establish procedures for the implementation of such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services and suppliers, including those not in high risk areas designated under paragraph (1).

''(3) COMPETITIVE BIDDING.—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

''(4) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate in the most recent report submitted to Congress under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year.

SEC. 5. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SEC. 1899. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

''(a) IN GENERAL.—The Secretary of Health and Human Services shall establish procedures for the use of technology (similar to that used with respect to the analysis of credit card charging patterns) to provide real-time data analysis of claims for payment under the Medicare program under title XVIII of the Social Security Act to identify and investigate unusual billing or order practices under the Medicare program that could indicate fraud or abuse.

''(b) COMPETITIVE BIDDING.—The procedures established under subsection (a) shall ensure that the implementation of such technology is conducted through a competitive bidding process.''.

SEC. 6. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.

Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

''(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

''(i) that the National Provider Identifier of the physician or practitioner prescribing or ordering the item or service is valid and active;

''(ii) that the Medicare identification number of the supplier is valid and active; and

''(iii) that the item or service for which the claim for payment is submitted was properly identified on the CMS–855S Medicare enrollment application.

''(B) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, accreditors, carriers, and the National Supplier Clearinghouse to view information on specialties and the types of items and services each supplier has indicated on the CMS–855S Medicare enrollment application submitted by the supplier.

''(C) NOTIFICATION OF CLAIM DENIAL AND RESUBMISSION.—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

''(i) the National Supplier Clearinghouse shall—

''(I) provide the supplier written notification of the reason for such denial; and

''(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accreditation; and

''(ii) the Secretary shall waive applicable requirements relating to the time frame for the submission of claims for payment under this title in order to permit the resubmission of such claim if payment of such claim would otherwise be allowed under this title.''.

SEC. 7. STRATEGIC PLAN FOR THE DEVELOPMENT OF A SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.

Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), as amended by section 6(a), is amended by adding at the end the following new paragraph:

''(23) STRATEGIC PLAN FOR THE DEVELOPMENT OF A SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall develop a strategic plan for the development and implementation of a serial number tracking system for durable medical equipment.

''(B) SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.—The plan developed under subparagraph (A) shall include mechanisms to ensure that an item of durable medical equipment which has not been issued a unique identifier under the unique device identification system established under section 519(f) of the Federal Food, Drug, and Cosmetic Act bears a unique identifier, unless the Secretary already requires an alternative placement or provides an exception for a particular item or type of durable medical equipment under such section 519(f).

''(C) PROVISION OF UNIQUE IDENTIFIER TO THE SECRETARY.—The plan developed under subparagraph (A) shall include appropriate mechanisms for manufacturers of items of durable medical equipment to submit to the Secretary unique identifiers issued under subparagraph (B) or such section 519(f) with

respect to such items. The plan shall include mechanisms for the Secretary to provide for the storage of such unique identifier in accordance with subparagraph (F)(i).

''(D) REQUIREMENTS FOR MANUFACTURERS AND WHOLESALERS.—The plan developed under subparagraph (A) shall include mechanisms for manufacturers of items of durable medical equipment, or, in the case where a wholesaler provides an item of durable medical equipment to suppliers, wholesalers, to—

''(i) upon issuing an item to a supplier, develop a product description for the item which includes—

''(I) the unique identifier of the item;

''(II) the specific Healthcare Common Procedure Coding System (HCPCS) code for the item;

''(III) the name of the supplier the item was shipped to; and

''(IV) the supplier's Medicare identification number; and

''(ii) submit the product description developed under clause (i) to the Secretary for storage in the unique identifier database in accordance with subparagraph (F)(i).

''(E) REQUIREMENTS FOR SUPPLIERS.—The plan developed under subparagraph (A) shall include mechanisms to ensure that suppliers of items of durable medical equipment—

''(i) upon issuing the item to a beneficiary, note the unique identifier of such item on—

''(I) the claim form submitted for such item; and

''(II) when appropriate or otherwise required, the detailed product description of the item;

''(ii) in the case where the item is issued to a beneficiary on a rental basis, designate the unique identifier with an 'R' after the number to indicate that the item was rented, and not purchased, by the beneficiary; and

''(iii) upon return of the item to the supplier, notify the Secretary—

''(I) before reissuing that item and resubmitting that number on such a claim form; or

''(II) upon resubmitting that number on such a claim form.

''(F) RESPONSIBILITIES FOR THE SECRETARY.—

''(i) MAINTENANCE OF DATABASE OF SERIAL NUMBERS.—The plan developed under subparagraph (A) shall include the responsibility of the Secretary to establish and maintain a database containing the unique identifiers submitted by manufacturers of items of durable medical equipment under subparagraph (C).

''(ii) PAYMENT.—

''(I) LIMITATION.—Subject to subclause (II), the plan developed under subparagraph (A) shall include mechanisms to ensure that payment may only be made for an item of durable medical equipment if the unique identifier on the claim form submitted for such item matches the unique identifier submitted by the manufacturer of such item under subparagraph (C).

''(II) EXCEPTION TO LIMITATION AFTER VERIFICATION OF RECEIPT.—The plan developed under subparagraph (A) shall include mechanisms to ensure that in the case where the unique identifier is not on the claim form submitted for such item or does not match the unique identifier submitted by the manufacturer of such item under subparagraph (C), no payment shall be made under this part for the item of durable medical equipment until the Secretary has verified that the beneficiary has received such item in accordance with subclause (IV).

''(III) DUPLICATIVE UNIQUE IDENTIFIERS.—The plan developed under subparagraph (A) shall include mechanisms to ensure that in the case where a unique identifier is submitted on more than 1 claim form submitted for such an item and there is no indication from the supplier that the item of durable medical equipment has been returned by 1 beneficiary and is now being used by another beneficiary, no payment shall be made under this part for such item of durable medical equipment unless the Secretary has verified that the beneficiary has received such item in accordance with subclause (IV).

''(IV) VERIFICATION.—The plan developed under subparagraph (A) shall include provisions for the Secretary to conduct any verification required under subclause (II) or (III) within 30 days after receipt by the Secretary of the relevant claim form. In the case where such verification is not completed within such time period, the Secretary shall pay such claim, complete the verification, and, in the case where the Secretary has entered into a contract with an entity for the conduct of such verification, recover any payments that would not have been made if the verification had been completed within such time period from such entity.

''(iii) QUALITY CONTROL AUDITS.—The plan developed under subparagraph (A) shall include a requirement that the Secretary conduct quality control audits to identify unusual billing patterns with respect to items of durable medical equipment for which payment is made under this part and may provide that the Secretary conduct unannounced site visits or commission other agencies to conduct such site visits as part of such quality control audits.

''(iv) NO USE AS A PRECERTIFICATION MECHANISM.—The plan developed under subparagraph (A) shall include mechanisms to ensure that in no case shall a unique identifier issued under subparagraph (B) or section 519(f) of the Federal Food, Drug, and Cosmetic Act be used as a precertification mechanism for the supply of an item of durable medical equipment or the payment of a claim for such an item under this part.''.

SEC. 8. GAO STUDY AND REPORT ON EFFECTIVENESS OF SURETY BOND REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT IN COMBATING FRAUD.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) in combating fraud.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

NOTICE OF HEARING

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a business meeting has been scheduled before Committee on Energy and Natural Resources. The business meeting will be held on Wednesday, December 16, 2009, at 11:30 a.m., in room SD–366 of the Dirksen Senate Office.

The purpose of the business meeting is to consider pending legislation.

For further information, please contact Sam Fowler at (202) 224–7571 or Amanda Kelly at (202) 224–6836.

PRIVILEGES OF THE FLOOR

Mrs. MURRAY. Mr. President, I ask unanimous consent that Richard Burkard, a detailee from the Government Accountability Office to the Appropriations Committee, be granted the privilege of the floor during consideration of the consolidated appropriations bill.

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

ORDERS FOR SATURDAY, DECEMBER 12, 2009

Mr. MENENDEZ. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9 a.m., Saturday, December 12; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the conference report accompanying H.R. 3288, the consolidated appropriations bill, as provided for under the previous order.

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

PROGRAM

Mr. MENENDEZ. Mr. President, at 9:30 a.m., the Senate will proceed to a cloture vote on the consolidated appropriations conference report. If cloture is invoked, the Senate will proceed to vote on the adoption of the conference report at 2 p.m. on Sunday.

ORDER FOR ADJOURNMENT

Mr. MENENDEZ. Finally, I ask unanimous consent that following the remarks of the distinguished Senator from Nevada, Senator ENSIGN, the Senate adjourn under the previous order.

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

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

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. I ask unanimous consent that I be able to speak as long as I take tonight and then following my comments, the Senate stand in adjournment.

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

Mr. ENSIGN. Mr. President, first, I wish to say to my friend from New Jersey, I appreciate the remarks he has made. I have stood with the Cuban people and especially with the dissidents down there for years, many times with my friend from New Jersey. I appreciate the issue he is bringing up and fighting for those folks.

There have been those cases over the years where American voices have reached all the way into those gulags, whether it was the old Soviet Union or North Korea or wherever it may be. America being the beacon of hope for so many people around the world, it is critical that Members of this body, as well as the President of the United

States, speak out for freedom and speak out for those people to give them hope that there are people in America who are listening and who are paying attention to them, so they will keep fighting for freedom in their own country. So I appreciate the comments the Senator from New Jersey made tonight.

OMNIBUS APPROPRIATIONS

I rise tonight, though, to speak about the legislation that is before the Senate. It is the Consolidated Appropriations Act or, as some people call it, the mini bus. This is a $447 billion bill. Around here, that seems like a small number. I believe this spending bill represents yet another step in the wrong direction for our country. I believe this legislation is only more of the same old recipe of fiscal irresponsibility that guides the majority in Congress. In a time of sky-high budget deficits and staggering debt, the American people are now demanding a better way forward.

I wish to make it clear for the record what this legislation does. As a Senate Budget Committee analysis shows, this bill increases spending by 12 percent over last year's fiscal year for the six spending bills that are wrapped up in this legislation. When we look at each of these bills separately, the numbers are even more shocking. The State Department received a 33-percent increase over last year. Transportation, Housing, and Urban Development received a 23-percent increase over last year. Keep in mind that these accounts together received more than $60 billion of increase in the stimulus bill that was signed earlier this year.

When we look at the gritty details, for example, at individual programs, the numbers are just as bad. The bill increases the Corporation for National Community Service by 30 percent and includes a 41-percent increase for bilateral economic assistance. There is also a 9-percent increase in Amtrak, and keep in mind that Amtrak got a $1.3 billion extra amount of money in the stimulus bill this year.

These spending increases are set against a dire economic picture. According to the nonpartisan Congressional Budget Office, in fiscal year 2010, the deficit will be $1.4 trillion. Right now, American families are hurting. I know my home State of Nevada has experienced some of the highest unemployment levels in the country—13 percent, according to the Department of Labor. In talking to constituents back home, I can guarantee my colleagues it is actually much higher. We have a situation where because people quit looking for jobs, the unemployment rate is understated. In my State is probably closer to 20 percent.

Democrats expect this bloated spending bill to receive what has become a customary rubberstamp when it comes to spending in this town. But I don't see how a $300,000 earmark to Carnegie Hall in New York City or $250,000 for a bike path in Michigan can be considered responsible spending during the economic times we are in. There are over 5,000 earmarks in this omnibus bill, this mini bus bill, whatever you want to call it, that is before us today—5,000 earmarks.

Not surprisingly, with all this spending, the majority in Congress must increase the debt limit. The debt limit is the limit set by Congress of how much debt our country can take on. This is similar, if you think about it, to your credit card limit. Right now, the debt limit is set at a little over $12 trillion—trillion. Let me take a little side note. We speak about trillions of dollars anymore as though it is nothing. Well, to put $1 trillion in a little bit of perspective—I have said this on this floor before—if you spend $1 million a day, 7 days a week, 365 days a year, to get to $1 trillion, you would have had to start spending that $1 million a day every day from the time Jesus was born, spend it until now, and you still wouldn't be at your first $1 trillion. Yet our country already has $1 trillion in debt.

Anyway, the majority is raising the debt limit. This would be akin to taking your credit card and maxing it out but then going to the bank and saying: By the way, can I increase my credit limit by 20 percent? Oh, by the way, I have no idea how I am going to pay it back, except maybe my children will be able to pay it back someday. That is exactly what this Congress is doing. We are saying: We can't pay this debt back. There is no way we can pay this debt back. Maybe our children, maybe our grandchildren can pay it back.

Americans across the country are going through tough times and they are doing what many in this body are unwilling to do. They are tightening their belts and cutting back on spending. According to the Federal Reserve, household debt has been reduced by $351 billion in the last quarter. This is the largest quarterly decline in our Nation's history. That is right. American families see the danger of fiscal irresponsibility and they are cutting back on borrowing the money they may have trouble paying back. State governments, local governments, businesses are doing the same as American families: They are cutting back.

We also have interest we must pay on this debt. Just like the interest you pay on your credit card when you carry a balance, Americans pay interest on the debt this country continues to accumulate. CBO estimates today the annual interest on this Nation's debt last year was around $179 billion—a big number, $179 billion. A lot of good could be done with that if we weren't just spending that, paying the interest on the debt. Well, that $179 billion by the year 2019 is projected to go to almost $800 billion, not including any of the new spending programs that are being proposed out there—$800 billion a year. As much as we are spending on our national defense will just be interest on our debt.

My friends on the other side of the aisle have made it a habit to come down to the Senate floor and say: Well, where were Republicans when President Bush was in office, adding to the debt, increasing the deficit? Well, I was right here saying many of the same things I am saying today. Not only did I vote against many of the spending bills that were passed during the previous administration, but I would have liked to have seen President Bush put his foot down and veto some of these bills and force Congress to cut back on out-of-control spending.

If President Obama is worried about the debt that his children and grandchildren are going to inherit, he has a hard time showing it. It seems to me the President is in denial regarding the fiscal train wreck that is taking place in this country.

In July of this year, President Obama said he understands the concern about the debt and admitted his recovery plan has added to the growing debt. But he stated at the time that now is not the time to tighten our belt and stop spending.

In November, however, President Obama said:

> I think it is important, though, to recognize that if we keep adding to the debt, even in the midst of the recovery, that at some point, people could lose confidence in the U.S. economy in a way that could actually lead to a double-dip recession.

First, the President says we must keep spending, even during the recession. Then he says that continued spending and increasing the debt during the recession could lead to a lack of confidence in the U.S. economy by the American people and by people around the world.

The President remains in his state of denial because before us is a $447 billion bill that he will likely sign into law.

I challenge President Obama to show leadership and veto this bill. Say to the Senate and the House of Representatives: Get your fiscal house in order. It is time we show responsibility to our children and grandchildren. Spending this year has added up a little bit. The TARP—an additional $350 billion was added to the TARP program this year. This has now become a slush fund. The stimulus bill was $787 billion. It was supposed to not allow the unemployment rate to go over 8 percent. We now know the unemployment rate is 10 percent. There were supposed to be millions of jobs saved or created. That certainly doesn't appear to be the case. In this stimulus bill, we see that $6 million will go to a PR firm whose head is a former pollster for a high-ranking member in the Obama administration. Again, that was for $6 million. That was to educate folks on what it means to go from analog television to digital. I don't know if anybody watched TV this last year, but the cable companies, the broadcasters, spent tens and tens of millions of dollars to tell folks about the transition and what it meant to

transition from analog to digital. Walmart and other companies that were selling the converter boxes were telling people about it. The government didn't need to spend this money. The private sector was handling it just fine.

That is just one small example of the wasteful spending that was part of the stimulus bill. My State has a 13-percent unemployment rate, as I mentioned before. So the stimulus bill certainly doesn't seem to have helped my State.

I want to show you what we are facing with this debt. Under the President's budget that was passed earlier this year, the debt will double within 5 years, and it will actually triple within 10 years. The debt that this country is taking on will double within 5 years and triple within 10 years.

Now we are going to add a $2.5 trillion health care bill, which is what the spending will be when it is fully implemented. The other side of the aisle has said that it actually decreases the deficit. That is part of the smoke and mirrors. You get all of the tax increases and the Medicare cuts in the first few years, but the actual benefits don't start until 2014. So if you look at a true 10-year picture, the spending in the bill is about $2.5 trillion.

On top of that, the bill I am talking about today, the $447 billion ''minibus'' of appropriations bills, is a 12-percent increase from last year to this year. When are we going to get the message from the American people? In the past, it doesn't seem like they cared that much about the debt and deficit. We are hearing about it all across the country today. That is the reason you're seeing in poll after poll that it is one of the big things the American people are concerned about now. I am happy they are finally paying attention. I just hope this body starts paying attention to what the American people are saying.

Mr. President, now I want to turn my attention to the DC Opportunity Scholarship Program and how the bill that is before us would eliminate this vital and successful program.

This omnibus bill would accomplish this by restricting the enrollment of any new students and lead to the end of the program. As many of you know, the DC Opportunity Scholarship Program is part of a comprehensive strategy designed to provide a quality education for every child in the District, regardless of income or neighborhood.

The District roundly supports this program. DC's mayor, Adrian Fenty, testified in favor of the program. He has sent letters of support to Members of Congress regarding the scholarship program.

Other DC leaders have also expressed their support, including City Council Chairman Vincent Gray, DC Public School Chancellor Michelle Rhee, and former Mayor Anthony Williams.

The residents support the program too. A Greater Washington Urban League Poll found that almost 70 percent of DC residents support this education funding.

Although the Chancellor of Public Schools, Michelle Rhee, has made much progress reforming DC's public schools, there is still much work to do.

The statistics paint a grim picture. According to the Department of Education's National Assessment of Education, DC ranked last in the Nation based on fourth and eighth grade reading assessments.

In 2007, only 14 percent of fourth graders—14 percent—were proficient in reading and math in DC schools. DC's overall performance on SATs is not much better. Reading scores are 32 points below the national average, while math scores are 60 points below the national average.

DC has some of the highest levels of per-pupil spending in the Nation. Unfortunately, this large investment is bearing little fruit.

The biggest tragedy of all is that a quality education represents the best chance for most of these children to escape the cycle of poverty that so many of their families are in today. For many, the DC Opportunity Scholarship Program provides that chance.

The average household income of participating families that get these scholarships is $22,000 a year for a family of four. All participating students come from families below 185 percent of the poverty line. Nearly 100 percent of the participating students are minorities.

Eighty-six percent of the scholarship students would otherwise be assigned to attend a DC public school that did not meet the ''adequate yearly progress'' standards in 2006 and 2007 and are in need of improvement, corrective action, or restructuring.

Unfortunately, many of the Democrats in this body continue to put politics ahead of a program that is helping to ensure low-income children have the ability to attend safe and effective schools.

Some opponents of the DC Opportunity Scholarship say the program isn't effective. They say it doesn't work and only diverts money from DC public schools. I simply disagree, and I believe the facts paint a very different picture, a more accurate representation of the success of the scholarship program.

According to Dr. Patrick Wolf at the University of Arkansas, the principal investigator studying the scholarship program, this program is working.

DC opportunity scholarship recipients show the largest achievement impact in reading of any education policy program yet evaluated in a randomized control trial. These randomized trials are the gold standard when it comes to figuring out whether a program works.

While the numbers paint an encouraging picture, I think 90 percent of parents of children in the program who say that the scholarship program gives their child a chance at a quality and safe education is a better measure.

David Martinez, whose daughters, Brenda and Katherine, already attend Sacred Heart through the scholarship program, wanted his youngest daughter, Heidi, to enroll as well.

David writes:

> I wanted my 5-year-old daughter, Heidi, to attend a private school, as well. I was overjoyed when we received a letter—telling us that the scholarship had been granted. Then, two weeks later—because President Obama, the Congress, and Education Secretary Arne Duncan sided against my daughter—we received another letter. This letter said that Heidi wouldn't receive her scholarship. We were devastated when we read the letter.

Patricia Williams writes of her son Fransoir. Before the program, she worried how she could help Fransoir get a good education and make sure he was safe and supervised. Patricia hopes that all her children attend college in the future.

Despite the fact that the parents and students involved in the DC Opportunity Scholarship have pleaded with lawmakers to preserve the program, Democrats continue to advocate eliminating the opportunity for more than 1,700 students to continue attending private schools.

When you look close at the data on DC schools, it is no wonder that the DC Opportunity Scholarship parents are so vocal about keeping the program alive. Per-pupil expenditures in the District public schools are more than $14,000 per pupil per year, and DC class size is one of the lowest, 14 to 1 student-teacher ratio. Yet reading scores continue to languish at or near the bottom in every national assessment.

Recent data shows that 69 percent of fourth graders are reading below basic levels, as defined by the Department of Education in Washington, DC.

DC students in DC public schools rank last in the Nation in both SAT and ACT scores.

Beyond the low performance in the classrooms, DC schools are often violent and dangerous. A Federal Government study found that 12 percent of DC students were threatened or injured by a weapon on school property during a recent school year—well above the national average.

Would most Americans put up with those kinds of statistics, or would they fight for change? This body has to fight for the students and the parents in Washington, DC.

According to the Washington Post, Anacostia High School alone saw 61 violent offenses, including 3 sexual assaults and 1 instance of the use of a deadly weapon.

Perhaps these facts are why President Obama has chosen to enroll both of his daughters in a private school in Washington.

Clearly, we can do better, and the DC Opportunity Scholarship Program is a means to achieve better results for low-income children in Washington.

There are promising signs that this program works. My colleagues, including Senators on both sides of the aisle—Senators LIEBERMAN, COLLINS,

FEINSTEIN, VOINOVICH, BYRD, and ALEXANDER—have joined in a bipartisan bill to improve and extend this successful program.

This program should not see its death through the appropriations process.

In conclusion, what this ''minibus''—the bill before us today—is doing is rolling over the future of this country. Call it what you want—minibus, omnibus, or 18 wheeler—it is carrying a load of debt and wasteful spending and government irresponsibility. It is a reminder to the American people that while they balance their budgets and scrape to pay their bills and try to save something for the future, the Federal Government continues its reckless shopping spree and just prints the money. This is not what we are sent here to do. I hope the President sees that and vetoes this irresponsible legislation.

I yield the floor.

ADJOURNMENT UNTIL 9 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9 a.m. tomorrow.

There being no objection, the Senate, at 7:44 p.m., adjourned until Saturday, December 12, 2009, at 9 a.m.

NOMINATIONS

Executive nominations received by the Senate:

TENNESSEE VALLEY AUTHORITY

MARILYN A. BROWN, OF GEORGIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY FOR A TERM EXPIRING MAY 18, 2012, VICE SUSAN RICHARDSON WILLIAMS, TERM EXPIRED.

NUCLEAR REGULATORY COMMISSION

WILLIAM CHARLES OSTENDORFF, OF VIRGINIA, TO BE A MEMBER OF THE NUCLEAR REGULATORY COMMISSION FOR THE REMAINDER OF THE TERM EXPIRING JUNE 30, 2011, VICE DALE KLEIN, RESIGNED.

DEPARTMENT OF DEFENSE

SHARON E. BURKE, OF MARYLAND, TO BE DIRECTOR OF OPERATIONAL ENERGY PLANS AND PROGRAMS. (NEW POSITION)

FOREIGN SERVICE

THE FOLLOWING-NAMED PERSONS OF THE AGENCIES INDICATED FOR APPOINTMENT AS FOREIGN SERVICE OFFICERS OF THE CLASSES STATED.

FOR APPOINTMENT AS FOREIGN SERVICE OFFICER OF CLASS THREE, CONSULAR OFFICER AND SECRETARY IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA,

DEPARTMENT OF STATE

SEAN J. MCINTOSH, OF NEW YORK

FOR APPOINTMENT AS FOREIGN SERVICE OFFICER OF CLASS FOUR, CONSULAR OFFICER AND SECRETARY IN THE DIPLOMATIC SERVICE OF THE UNITED STATES OF AMERICA:

DEPARTMENT OF STATE

JILLIAN FRUMKIN BONNARDEAUX, OF VIRGINIA
LYNDA J. HINDS, OF CALIFORNIA

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

DEPARTMENT OF STATE

RYAN AIKEN, OF UTAH
R. ANDREW ALLEN, OF GEORGIA
NATALIA ALMAGUER, OF FLORIDA
LAURA AYLWARD, OF WASHINGTON
JENNIFER AZARI, OF NEW JERSEY
KARA B. BABROWSKI, OF FLORIDA
ZACHARY BAILEY, OF VIRGINIA
JUDITH E. BAKER, OF MASSACHUSETTS
ESTHER F. BELL, OF RHODE ISLAND
IRMIE KEELER BLANTON III, OF GEORGIA
CHELAN J. BLISS, OF WASHINGTON
DAVID SEAN BOXER, OF VIRGINIA
ALEXIA MCNEAL BRANCH, OF CALIFORNIA
RAVI FRANKLIN BUCK, OF MISSOURI
MATTHEW BUSHELL, OF CONNECTICUT
OMAR CARDENTEY, OF FLORIDA
DANIEL C. CARROLL, OF HAWAII
ANDREW N. CARUSO, OF VIRGINIA
MICHAEL P. CASEY, OF VIRGINIA
BENJAMIN COCKBURN, OF GEORGIA
JOANNE ILENE COSSITT, OF CONNECTICUT
ROCCO COSTA, OF MARYLAND
CHRISTOPHER B. CREAGHE, OF COLORADO
ROBIN S. CROMER, OF SOUTH CAROLINA
GAETAN DAMBERG-OTT, OF MINNESOTA
JESSICA RENEE DANCEL, OF COLORADO
SCOTT B. DARGUS, OF WASHINGTON
PETER JOHN DAVIDIAN, OF OHIO
REBEKAH E. DAVIS, OF THE DISTRICT OF COLUMBIA
JASON DYER, OF NEW MEXICO
MARCUS GEORGE FALION, OF TENNESSEE
GAIL HEGARTY FELL, OF NEW YORK
JOSEPH ANTON FETTE, OF CALIFORNIA
AARON ELLIOTT GARFIELD, OF CALIFORNIA
PHILLIP M. GATINS, OF FLORIDA
SARAH GJORGJIJEVSKI, OF VIRGINIA
SAMUEL EVERETT GOFFMAN, OF ILLINOIS
DANIEL ROSS HARRIS, OF CALIFORNIA
NOEL HARTLEY, OF THE DISTRICT OF COLUMBIA
JANEL MARGARET HEIRD, OF MICHIGAN
PEPIJN M. HELGERS, OF THE DISTRICT OF COLUMBIA
CHRISTOPHER D. HELMKAMP, OF VIRGINIA
WILLIAM N. HOLTON, JR., OF ILLINOIS
TRAVIS A. HUNNICUTT, OF VIRGINIA
DONNA J. HUSS, OF INDIANA
MOUNIR E. IBRAHIM, OF NEW YORK
AMENAGHAMWON IYI-EWEKA, OF WISCONSIN
DANA MARIE JEA, OF FLORIDA
JOANNA TRACY KATZMAN, OF NEW JERSEY
JENNIFER ANNE KELLEY, OF THE DISTRICT OF COLUMBIA
CRAIG S. KENNEDY, OF GEORGIA
THOMAS D. KOHL, OF FLORIDA
JACK C. LAMBERT, OF OREGON
BRENT JOSEPH LAROSA, OF MARYLAND
ALEXI LEFEVRE, OF FLORIDA
IAN MACKENZIE, OF MASSACHUSETTS
JUAN D. MARTINEZ, OF NEW YORK
KELLY JEAN MCANERNEY, OF PENNSYLVANIA
MAUREEN A. MCNICHOLL, OF ILLINOIS
GREGORY MEIER, OF CALIFORNIA
MARC A.J. MELINO, OF WASHINGTON
MATAN MEYER, OF FLORIDA
BENJAMIN J. MILLS, OF NEW MEXICO
SEAN P. MOFFATT, OF MARYLAND
CHARLES VINCENT MURPHY, OF CALIFORNIA
LINDA A. NEILAN, OF NEW JERSEY
EMILY YASMIN NORRIS, OF MASSACHUSETTS
ELIZABETH CURRAN O'ROURKE, OF ILLINOIS
MARY LILLIAN PELLEGRINI, OF NEW HAMPSHIRE
LISA MARIE PETZOLD, OF MASSACHUSETTS
KATHRYN STANSBURY PORCH, OF MARYLAND
MARIA DEL PILAR QUIGUA, OF MASSACHUSETTS
RYAN M. QUINN, OF WISCONSIN
SCOTT RULON RASMUSSEN, OF WASHINGTON
LEA PALABRICA RIVERA, OF NEW YORK
TANYA ELAINE ROGERS, OF TEXAS
SUSAN ROSS, OF NEW YORK
ZACHARY R.S. ROTHSCHILD, OF THE DISTRICT OF COLUMBIA
LAUREN C. SANTA, OF THE DISTRICT OF COLUMBIA
TODD BENSON SARGENT, OF VERMONT
MONICA A. SLEDJESKI, OF NEW YORK
MATTHEW BOUTON STANNARD, OF CALIFORNIA
MATTHEW M. STEED, OF CALIFORNIA
DAVID S. STIER, OF NEW YORK
ANNA STINCHCOMB, OF THE DISTRICT OF COLUMBIA
CASSIE COADY SULLIVAN, OF NEW YORK
VIOLETA TALANDIS, OF MARYLAND
DANIEL J. TARAPACKI, OF NEW YORK
TIMOTHY TRANCHILLA, OF THE DISTRICT OF COLUMBIA
GREGORY J. VENTRESCA, OF NEW YORK
DOMINGO J. VILLARONGA, OF NEW YORK
NICHOLAS VON MERTENS, OF NEW HAMPSHIRE
DARREN WANG, OF CALIFORNIA
THOMAS CHARLES WEBER, OF TEXAS
JOHN NOEL WINSTEAD, OF WYOMING
WILLIAM QIAN YU, OF WASHINGTON

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be colonel

NOEMI ALGARINLOZANO
CAROL ANN BARCLA ANDREWS
SUSAN F. BALL
SUSAN E. BASSETT
YOLANDA D. BLEDSOE
KEVIN J. BOHAN
KAREN L. CHURCH
STEPHEN K. DONALDSON
CAROLE A. FARLEY
ANNETTE S. GABLEHOUSE
VIRGINIA A. GARNER
DANIEL E. GERKE
PENELOPE F. GORSUCH
VIVIAN C. HARRIS
MADELINE D. HOWELL
AMELIA L. HUTCHINS
BILLYE G. HUTCHISON
DENISE R. IRIZARRY
ALETA P. JEFFERSON
GUYLENE D. KRIEGHFLEMING
DEBORAH R. MARCUS
ELEANOR C. NAZARSMITH
DEAN L. PRENTICE
JAMES E. REINEKE
THERESA D. RODRIGUEZ
LISA A. SCHMIDT
ROBIN L. SCHULTZE
KAREN L. SCLAFANI
JULIA G. STOSHAK
CHRISTINE S. TAYLOR
MARY M. WHITEHEAD
PATRICK J. WILLIAMS

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be colonel

DAVID W. BOBB
CHARLES R. CARLTON, JR.
CRAIG J. CHRISTENSON
DAVID COHEN
JAMES H. DIENST
BRIDGET C. GREGORY
SAMUEL D. HALL III
ALVIS W. HEADEN III
STEVEN R. HINTEN
DOUGLAS C. HODGE
BAILEY H. MAPP
DANIEL E. REISER
LONDON S. RICHARD
ERIC A. SHALITA
MARK E. SMALLWOOD
BRIAN K. STANTON
JAY M. STONE
ROBERT W. WISHTISCHIN

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be colonel

RANDALL M. ASHMORE
ADAM G. BEARDEN
SCOTT T. BROWN
MICHAEL S. BURKE
HEATHER M. CARTER
ROBERT R. EDWARDS, JR.
KURTIS W. FAUBION
D. SCOTT GUERMONPREZ
JASON T. HALL
SCOTT J. HILMES
THOMAS M. HUNTER
JEFFERY F. JONES
ELMO J. ROBISON III
R. BRUCE ROEHM
HERBERT C. SCOTT
JAMES A. SPERL

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be colonel

SEAN W. DIGMAN
LARRY J. EVANS
TOMMY D. FISHER
MICHAEL E. FULTON
ALLEN J. HEBERT, JR.
GERALD P. KABAN
ANGELA M. MONTELLANO
JACOB E. PALMA
HYEKYUNG HELENA PAE PARK
PHILLIP C. PORTERA
ROGER E. PRADELLI
ROBERT V. REINHART, JR.
DAVID L. ROBINSON

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be colonel

ALBERT H. BONNEMA
MARK J. BROOKS
MARY T. BRUEGGEMEYER
JAMES H. BURDEN, JR.
BRET D. BURTON
THOMAS N. CHEATHAM
NICOLA A. CHOATE
BRANDON D. CLINT
CHARLES D. CLINTON
MARK R. COAKWELL
MARCUS M. CRANSTON
BRIAN K. CROWNOVER
ERIC W. FESTER
DAVID GARRETT, JR.
PHILIP L. GOULD
PAUL E. GOURLEY
NABIL M. HABIB
BENJAMIN A. HARRIS
KAREN A. HEUPEL
JAMES L. JABLONSKI II
WILMER T. JONES III
JAMES A. KEENEY
MICHAEL R. KOTELES
JOHN P. LYNCH
DEBRA L. MALONE
RANDY O. MAUFFRAY
RANDALL R. MCCAFFERTY
KENT D. MCDONALD
WILLIAM F. MOORE
PAUL H. NELSON
MARRINER V. OLDHAM
TIMOTHY R. PAULDING
GARY A. PEITZMEIER
TODD W. POINDEXTER

MICHAEL G. RAPPA
TODD E. RASMUSSEN
ROCKY R. RESTON
JOANN Y. RICHARDSON
EDGAR RODRIGUEZ
LOWELL G. SENSINTAFFAR
STACY A. SHACKELFORD
TERESA M. SKOJAC
LEIGH A. SWANSON
MICHAEL S. TANKERSLEY
GRANT P. TIBBETTS
DEREK K. URBAN
SCOTT A. VANDEHOEF
BRYAN M. VYVERBERG
GEORGE A. WADDELL
LESLIE A. WILSON
RAWSON L. WOOD
JON B. WOODS
SCOTT D. ZALESKI
GIANNA R. ZEH

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant colonel

ERIC R. BAUGH, JR.
DORON BRESLER
STEPHEN H. CHARTIER
JILL A. CHERRY
ORLANDO L. COLONCONCEPCION
FREDERICK A. CONNER
GREGORY A. CONNER
MARVIN CONRAD
JONATHAN D. EVANS
DANIEL B. GABRIEL
MICHAEL T. GARDNER
CECILIA I. GARIN
DAVID E. HALL
DENNIS M. HOLT
DAVID M. JONES
MIKELLE L. KERNIG
JAMES DALE KISER, JR.
KELLI C. MACK
ROBERT K. MCGHEE
KATHERINE R. MORGANTI
BARRY F. MORRIS
JESSE MURILLO
JEANLUC G. C. NIEL
KYLE W. ODOM
INAAM A. A. PEDALINO
KYLE E. PELKEY
AIDA M. SOLIVANORTIZ
YOUNG K. SUNG
JOHN A. THOMAS
JAMES R. THOMPSON
WILLIAM K. TUCKER
GEORGE S. TUNDER, JR.
KARYN E. YOUNG

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant colonel

ADAM M. ANDERSON
BRETT C. ANDERSON
ROBERT S. ANDREWS
DAVID E. ANDRUS
MARIA M. ANGLES
MARY CATHERINE ARANDA
JORGE ARZOLA
SHAWN M. BAKER
KIMBERLY M. BALOGH
ANTHONY S. BANKES
JEFFREY W. BARR
PETRAN J. BEARD
RICHARD W. BENTLEY
JEFFREY J. BIDINGER
JAMES A. BLEDSOE
DENNIS F. BOND II
CRAIG D. BOREMAN
STACEY L. BRANCH
BRETT D. BRIMHALL
SCOT E. CAMPBELL
FRANCIS R. CARANDANG
GABRIELLA CARDOZAFAVARATO
DAVID H. CARNAHAN
BRYCHAN K. CLARK
DAREN S. DANIELSON
PAUL BARTOLOMEO DIDOMENICO
GEORGE M. DOCKENDORF
JAMISON W. ELDER
ANN S. FENTON
COLLEE FITZPATRICKWEISBROD
JAY T. FLOTTMANN
SARAH O. FORTUNA
CURTIS M. FOY
DOUGLAS S. FRENIA
KELLY D. GAGE
JOSEPH P. GALLAGHER
MICHAEL S. GARRETT
VERONICA M. GONZALEZ
THERESA B. GOODMAN
WADE T. GORDON
NOAH H. GREENE
LOUIS Q. GUILLERMO
ERIC S. HALSEY
DERRICK A. HAMAOKA
MATTHEW P. HANSON
KARIN N. HAWKINS
BRET D. HEEREMA
ERIC J. HICK
JAMES M. HITCHCOCK
CRYSTAL L. HNATKO
KYLE B. HUDSON
SCOTT W. HUGHES
TODD P. HUHN
JON R. JACOBSON
JOEL W. JENNE
DAVID S. JONES
LOREN M. JONES
THOMAS E. KIBELSTIS
PAUL KLIMO, JR.
MICHELE L. KNIERIM
JANA S. KOKKONEN
JAMES B. KOPP
ELLA B. KUNDU
NIRVANA KUNDU
ALEX J. LEE
JEFFREY D. LEWIS
KARYN C. LEWIS
KEEGAN M. LYONS
DANIEL S. MADSEN
CHARLES G. MAHAKIAN
MARIA I. MARTINO
PHILLIP E. MASON
DEREK A. MATHIS
EDWARD L. MAZUCHOWSKI II
HOWARD J. MCGOWAN
DONALD J. MCKEEL
MICHAEL D. MICHENER
QUINTESSA MILLER
BRIAN A. MOORE
PAUL M. MORTON
SAMUEL B. MUNRO
DANIEL H. MURRAY
HAFEZ A. NASR
BRETT R. NISHIKAWA
WILLIAM C. OTTO
SARAH M. PAGE
WESLEY D. PALMER
GILBERTO PATINO
JUDITH E. PECK
ALYSSA C. PERROY
TIMOTHY M. PHILLIPS
BRIAN J. PICKARD
ROBERT R. PORCHIA
TONYA S. RANS
NATALIE L. RESTIVO
MARK G. RIEKER
ERIC M. RITTER
JENNIFER M. RIZZOLI
MARK O. ROBINSON
KYLE M. ROCKERS
GEOFFREY T. SASAKI
STEPHANIE A. SAVAGE
CHRIS A. SCHEINER
STEPHEN E. SCRANTON
JIFFY C. SETO
ANDREA D. SHIELDS
DANIEL A. SHOEMAKER
REBECCA W. SHORT
TERESA A. SIMPSON
ROMMEL B. SINGH
JOHN HWA SLADKY
KEVIN E. STEEL
ELIZABETH DOKFA P. STEWART
MARK A. SUMMERS
DEENA E. SUTTER
LON J. TAFF
PATRICK J. THOMPSON
RAMONE A. TOLIVER
MARK S. TOPOLSKI
EDDIE H. UY
JOSEPH D. VILLACIS
KIRSTEN R. VITRIKAS
DANIEL R. WALKER
DAVID T. WANG
YUANHONG WANG
JOHN C. WHEELER
PATRICK F. WHITNEY
MAUREEN N. WILLIAMS
LEE T. WOLFE
GRAND F. WONG
ROGER A. WOOD
HENRY ALLEN WOODS, JR.
JOSHUA L. WRIGHT
JOY C. WU
SHAHID A. ZAIDI

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

BRIAN J. ALENT
AYMAN M. ALI
ZACHARY D. ALLMAND
ELIZABETH A. BOWMAN
JEFFREY R. BURROUGHS
JAN R. CARLSON
BENJAMIN T. CLARK
JEFFREY E. CULL
SHONNA R. CURRY
JESSICA N. DEAN
DAVID M. DENNISON
JENNIFER M. DEPEW
RYAN M. DIEPENBROCK
MATTHEW J. EDWARDS
JEFFREY D. FLEIGEL III
DANIEL D. FRIDMAN
BENJAMIN J. GANTT
LANNY J. GIESLER
PHILLIP J. HARVEY
CYNTHIA HERNANDEZFALU
SHAWNA N. HOFFERT
LAQUANIS S. HOOKER
LAWERENCE S. HORNE
HANLING H. JOSWICK
NEIL C. KESSEL
JONGSUNG KIM
JERED B. KING
KRISTEN B. KNODEL
AARON T. KRANCE
JAE S. LEE
LOUIS JOSEPH MARCONYAK, JR.
AMY G. MASON
SHAWN P. MCMAHON
BRENT A. MILNE
TAMARA A. MURRAY
LOSCAR N. PEREZVELEZ
COURTNEY A. SCHAPIRA
NICHOLAS D. SCHULTE
NATHAN T. SCHWAMBURGER
JELENA C. SEIBOLD
LORA R. SKEAHAN
DRAGOS STEFANDOGAR
JAMES R. VANDRE
LANCE R. WASHBURN
DENNIS J. WEBER II
RACHEL A. WEBER

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

ERIC E. ABBOTT
ERIK L. ABRAMES
VAN W. ADAMSON
JASON M. ALLEN
MICHAEL A. AROCHO
ANGELE J. ARTHUR
JOSEPH R. BABER
MICAH J. BAHR
CARRIE G. BAKER
ERIK A. BAKER
TROY W. BAKER
KEVIN J. BALDOVICH
JEREMY W. BALDWIN
JAMES R. BALES
RYAN A. BARENCHI
ROBERT T. BARIL
CHRISTOPHER W. BATES
GAIL C. BATES
CLAIRALYN L. BAUCOM
TIMOTHY S. BAUMGARTNER
ELIZABETH A. BEAL
AMY S. BECK
SCOTT J. BENTLEY
WILLIAM A. BETHEA
CHARLES A. BEVAN III
DAVID K. BIGELOW
BRANDON J. BINGHAM
CHRISTOPHER D. BLACK
KWABENA L. BLANKSON
CALE WALTER BONDS
KEVIN S. BORCHARD
ERNEST E. BRAXTON
HEATHER K. BRIGHT
PAMELA J. BRODERICK
AMY N. BROWN
DANIEL J. BROWN
MICHAEL J. BUYS
SUSAN J. CARBOGNIN
MICHAEL H. CARPENTER
KATRINA CARTER
DAVID J. CASSAT
ELISE M. CHAMBERS
NATALIE G. CHAN
MICHAEL J. CLEGG
NATHAN F. CLEMENT
TIMOTHY J. COKER
JASON A. COMPTON
TARA L. CONNER
JAMES R. COONEY
GEOFFREY J. COOPER
SUSANNAH C. COOPER
CHRISTINA L. CRISTALDI
SPENCER J. CURTIS
AUGUSTA L. CZYSZ
DANIEL F. DAVENPORT
AMY M. DAVIS
JESSICA M. DAVIS
RICHARD P. DAVIS
JONATHAN A. DAY
AUTUMN N. DEAN
MELISSA J. DOOLEY
BRANDEN G. DUFFEY
SPENCER G. DUNCAN
STEPHEN T. ELLIOTT
JONATHAN E. ELLIS
JOEL B. ELTERMAN
MICHELLE M. ENGELKEN
JOSEPH K. ERBE
WILLIAM R. ERRICO
DONALD S. EULER, JR.
ROGER N. EWONKEM
TIMOTHY D. FAGEN
SHANNON D. FARAG
DAVID D. FARNSWORTH
MELINDA G. FIERROS
COREY D. FINCH
AUSTIN D. FINDLEY
CARRIE E. FLANAGAN
STACY F. FLETCHER
FREDERICK L. FLYNT, JR.
CRISTINA L. FRANCHETTI
RYAN D. FREELAND
SHAWN K. FRENCH
SCOTT H. FRYE
DANIEL L. GALLO
JOHN G. GANCAYCO
RYAN F. GIBBONS
GUY N. GIBSON
SHAUN M. GIFFORD
PHILLIP J. GOEBEL
MICHELLE NICOLE GONZALEZ
JASON C. GOODWIN
ZACHARY P. GORAL

JOSE B. GOROSPE
MARIA E. GOROSPE
ERIC S. GRAJKOWSKI
GIOVI GRASSOKNIGHT
BRIAN J. GROAT
FREDERICK P. GROIS III
AJIT GUBBI
MICHELLE S. GUCHEREAU
MICHAEL S. HAMPTON
TRISTAN E. HANDLER
BRENT S. HARLAN
CORTNEY ELIZABETH HARPER
JEFFREY N. HARRIS
NOAL I. HART
WILLIAM A. HAYES II
KEVIN F. HEACOCK
SARAH M. HEDRICK
JASON A. HIGEY
JASON H. HINES
THAO T. B. HO
DIANE C. HOMEYER
JACOB G. HOOVER
WILLIAM R. HOWARTH
JUSTIN C. HUANG
ISAAC P. HUMPHREY
KYLE F. JARNAGIN
TAUNYA M. JASPER
KEVIN N. JENSEN
JULIE C. JERABEK
ASHLEY B. JOHNSON
COLLEEN N. JOHNSON
SARA KAY LUTTIO JOHNSTONE
FRANCES J. JONES
LASONYA D. JONES
OSCAR B. JONES
ROBERT J. JONES, JR.
KEVIN KALWERISKY
ALEXANDER P. KELLER IV
JARED C. KELSTROM
TIMOTHY P. KENNARD
KEIRON T. KENNEDY
SARA S. KERLEY
JONATHAN R. KEVAN
JEREMY P. KILBURN
DANNY S. KIM
JEFFREY D. KISER
DAVID A. KLEIN
ELIZABETH A. KLEWENO
SHANNON F. KLUMP
JOSHUA H. KNOWLES
JAMES B. KOCH
KATHERINE A. KOCZAN
CALEB E. KROLL
THOMAS J. KRYZAK
BRIAN D. LARSON
JOSHUA L. LATHAM
ZHI V. LAU
RANDY A. LEACH
CHRISTOPHER C. LEDFORD
RYAN S. LEE
JADE A. LHEUREUX
JOHN LICHTENBERGER III
APRIL LIGATO
PEICHUN LIN
SCOTT R. LINK
NANCY W. LO
GUSTAVO A. LOPES
WILLIAM N. LUTHIN
DUSTIN O. LYBECK
MEIKEL P. MAJOR
LOU ROSE M. MALAMUG
JELRIZA C. B. MANSOURI
DAVID J. MARTINEZ
AMELITA A. MASLACH
JOEL G. MASSEY
JAMIE A. MASSIE
RENEE I. MATOS
MICHAEL J. MATSUURA
MICHAEL J. MATTEUCCI
JEFFREY C. MCCLEAN
MARC D. MCCLEARY
RISPBA N. MCCRAYGARRISON
TORREE M. MCGOWAN
RYAN S. MCHUGH
CHRISTOPHER C. MEDINA
WAYNE J. MERBACK
BRADLEY R. MEYER
LISA R. MICHELS
CHARLES B. MILLER
SHANNA M. MOLINA
JEREMY D. MOLL
TYLAN A. MUNCY
BRIAN H. NEESE
COURTNEY R. NELSON
SHERWIN P. NEPOMUCENO
KHANG H. NGUYEN
JOSEPH D. NOVAK
VALERIE C. OBRIEN
KEVIN L. OLSON
ROBERT M. ORE
KATHRYN R. OUBRE
JEREMY W. OWENS
CHI NA PAK
BRET L. PALMER
BRUCE M. PALMER
BENJAMIN J. PARK
ROGER T. PARK
JASON D. PASLEY
JOSHUA B. PEAD
CANDACE S. PERCIVAL
SERAFIM PERDIKIS
SARA LYNN PETERSONSCHRADER
ANDREW J. PETERSON
KRISTINE K. PIERCE
DARREN S. PITTARD
BRANDON W. PROPPER
JAMIE M. RAND
PHILLIP J. REDD
ANDREW G. REES
SUSAN L. REESE
CHRISTOPHER A. REGNIER
STEVEN REGWAN
AMANDA B. RICHARDS
TIGHE C. RICHARDSON
JONATHAN M. RICKER
JILL E. ROTH
JUSTIN P. ROWBERRY
JAIME RUIZ PEREZ
PETER R. SABATINI
DERICK A. SAGER
STEPHEN C. SAMPLE
RICHARD J. SAXEN
RANDAL S. SCHOLMA
KARA S. SCHULTZ
ROSS A. SCHUMER
REBEKAH A. SENSENIG
TRISTAN L. SEVDY
JONATHAN B. SHAPIRO
CHARLOTTE A. SHEALY
MEHDI C. SHELHAMER
MARK E. SHEPHERD
GREGORY A. SKOCHKO
CLARISA I. SMITH
TRIMBLE L. SPITZER
TRAVIS A. STEPHENSEN
HEATHER L. STEWART
NORMAN E. STONE III
STEPHEN T. D. STOREY
LISA E. STRICKLAND
SARAH J. STRINGER
JAMIE M. SWARTZ
ROBERT C. SWIFT
RAMON N. THOMAS
ROGER S. THOMAS
GINA M. THOMASON
KATHERINE S. TILLE
PAUL A. TILTON
JAMES R. TOWNLEY
PETER T. TRAN
TIM P. TRAN
RONALD J. URTON
ANDREW R. W. VACLAVIK
FLORA P. VARGHESE
DOUGLAS R. VILLARD
ADAM P. VOSSEN
TERENCE E. WADE
DENNIS D. WALKER
ANDREW L. WALLS
YANG WANG
JEREMIAH R. WATKINS
LARISSA F. WEIR
CHRISTINA M. WELCH
DALIA J. WENCKUS
JENNIFER L. WHATLEY
BRAD E. WHEELER
CALEN N. WHERRY
BENJAMEN H. WILLIAMS
PHILIP A. WIXOM
EMILY B. WONG
AARON F. WOODWARD
JEFFREY S. WOOLFORD
BRIAN W. WRITER
DUOJIA XU
ETHAN EVERETT ZIMMERMAN

IN THE ARMY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY JUDGE ADVOCATE GENERAL'S CORPS UNDER TITLE 10, U.S.C., SECTIONS 624 AND 3064:

To be lieutenant colonel

OLGA M. ANDERSON
DAVID O. ANGLIN
JASON M. BELL
ROSEANNE M. BENNETT
DEIRDRE G. BROU
MARY E. CARD
JONATHAN E. CHENEY
HEATHER J. FAGAN
DANIEL M. FROEHLICH
DEON M. GREEN
JOHN A. HAMNER II
JAMES G. HARWOOD
TIMOTHY P. HAYES, JR.
KEVEN J. KERCHER
MAUREEN A. KOHN
RODNEY R. LEMAY
ERIC D. MAGNELL
ROBERT L. MANLEY III
ANDRAS M. MARTON
SEAN T. MCGARRY
OREN H. MCKNELLY
MICHAEL D. MIERAU, JR.
RUSSELL N. PARSON
KELLI L. PETERSEN
EMILY C. SCHIFFER
THOMAS E. SCHIFFER
CHRISTINE M. SCHVERAK
DAVID T. SCOTT
KARIN G. TACKABERRY
NELSON J. VANECK
AARON A. WAGNER
CHARLES W. WALLACE
SCOTT D. WALTERS
MARTIN N. WHITE
ERIC W. YOUNG
D004179

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR TEMPORARY APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS UNDER TITLE 10, U.S.C., SECTION 6222:

To be major

BRIAN J. DIX

IN THE AIR FORCE

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

To be brigadier general

COL. DIXIE A. MORROW

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

To be brigadier general

COL. PAUL S. DWAN

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be brigadier general

COL. DANIEL B. FINCHER
COL. DAVID C. WESLEY

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

To be brigadier general

COLONEL GARY C. BLASZKIEWICZ
COLONEL ARTHUR C. HAUBOLD
COLONEL MICHAEL D. KIM
COLONEL LINDA S. MARCHIONE
COLONEL RICHARD O. MIDDLETON II
COLONEL ROBERT N. POLUMBO
COLONEL JANE C. ROHR
COLONEL PATRICIA A. ROSE
COLONEL PETER SEFCIK, JR.
COLONEL JAMES F. SMITH
COLONEL EDMUND D. WALKER
COLONEL WILLIAM O. WELCH

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

VICE ADM. DAVID ARCHITZEL

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 5046:

To be major general

COL. VAUGHN A. ARY