PLEDGE OF ALLEGIANCE

The Honorable EDWARD E. KAUFMAN 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 22, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable EDWARD E. KAUFMAN, a Senator from the State of Delaware, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

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

RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health care legislation. The time until 7:18 this morning is equally divided and controlled between the two leaders or their designees. The Senate will then proceed to a series of three rollcall votes—they will be stacked—in relation to the Reid motion to table the Reid amendment No. 3278, the Reid-Baucus-Dodd-Harkin amendment No. 3276, and a motion to invoke cloture on the Reid substitute No. 2786. If cloture is invoked, the majority leader will then be recognized, and then the time until 9:30 will be equally divided and controlled between the two leaders or their designees. Beginning at 9:30 a.m. and until 5:30 p.m. today, the time will be controlled in alternating 1-hour blocks of time, with the Republicans controlling the first hour. The Senate will recess from 12:30 until 2:30 p.m. today for the weekly conferences.

CHRISTMAS PEACE

Mr. REID. Mr. President, tensions have been high because of this legislation which has been on the floor for a considerable period of time. I hope everyone understands that this part of the session is winding down, and I hope everyone will go out of their way to be thoughtful and considerate to those on both sides of the aisle. This is not the time for any personal attacks or anything that is acrimonious. It is time to figure out a way to leave here in a peaceful nature. We have the Christmas holiday coming, and we know how important that is to families. I hope everyone will work toward getting us out of here and back to our families as quickly as we can.

I designate the time the Democrats have remaining to Senator DURBIN, the majority whip.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

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

The legislative clerk read as follows:

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

Pending:

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

Reid amendment No. 3276 (to amendment No. 2786), of a perfecting nature.

Reid amendment No. 3277 (to amendment No. 3276), to change the enactment date.

Reid amendment No. 3278 (to the language proposed to be stricken by amendment No. 2786), to change the enactment date.

Reid amendment No. 3279 (to amendment No. 3278), to change the enactment date.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until expiration of cloture on amendment No. 3276 shall be equally divided and controlled between the two leaders or their designees.

The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I will be taking the leader time on our side. How much time is there?

The ACTING PRESIDENT pro tempore. Six minutes.

Mrs. HUTCHISON. I thank the Chair.

Mr. President, today we are taking another step toward passing a bill that has not seen the light of day for very long. It is a bill that is going to change health care policy in this country forever if it is finally coming to enactment. It will take effect in 2014. The reason we are talking about this bill and trying to let people know what is in it is because we hope there is still a chance this bill will not become law.

This bill was drafted behind closed doors without Republican input. The votes are 60 to 40. Sixty Democrats and 40 Republicans make up the Senate, and that is what is providing cloture on this bill.

This bill increases taxes by over $½ trillion over a 10-year period—that is over $500 billion—and $½ trillion in cuts to Medicare. This is a time when we should not be increasing taxes. Small businesses are burdened already. This adds to their burden. Families are trying to make ends meet. They are trying to pay their mortgage so they will not be thrown out of their homes. They are trying to pay their bills. They are trying to find jobs in the highest level of unemployment in our country since World War II, and we are going to heap taxes and burdens on them starting as early as next year—in 2 weeks. This is not a time to raise taxes. We don't need a tax burden increase, we don't need Medicare cuts, and we do need health care reform that would lower the cost of health care. This is going to do the opposite. We are going to increase taxes and lower the service for Medicare in our country.

I remember reading some of the history and the anecdotes about the vote on the constitutional amendment to allow women the right to vote. There was a Congressman from Tennessee who was wavering. He said what finally made up his mind—and he was the Congressman who made the difference—was that his mother wrote him a letter and said: Vote for ratification.

What is going to be said about this bill that changes health care policy for every American? What is going to be written about how the votes were brought together to have a bill that would tax our American people $½ trillion and take Medicare as the pay-for for this program is that there will be essential protection for seniors in Florida and New York to prevent them from suffering the cuts to Medicare Advantage but no other State. Insurance companies in only two States, Nebraska and Michigan, are exempt from the taxes that will take effect on insurance companies, raising the premiums for every insured person in this country. Changes to the language restricting physician ownership of medical facilities appear only to benefit a single medical center in Nebraska, and additional Federal payments to Louisiana, Massachusetts, Nebraska, and Vermont to expand Medicaid will cost taxpayers in every other State in America over $1 billion. This is part of the deal that was brokered to make sure 60 votes would pass this bill. The people of Nebraska will never pay a dime for Medicaid increases, whereas my State of Texas will carry a new burden of over $9 billion, and every other State in America will eventually take the burden of the Medicaid increases but not Nebraska, not ever. Even the Governor of Nebraska has said he does not think that is fair.

So I think we can do better. We can do better in this country than having the history of the overhaul of our health care system that is going to affect the quality of life and the tax burden on every American. I think we should have a better history.

So I am asking my colleagues to think about this vote. We could change one vote, one person who says: I don't

want the Senate to do something this way. I want the Senate to rise to the level that we know has been the tradition of this Senate for all of the years of our Republic, and that is that we would have an open, transparent process; that we would have bipartisan input; that a Republican amendment—one might have passed; that what we offer is what we promised the American people: lower costs in health care——

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mrs. HUTCHISON.—and a way for people to have more affordable access.

We still have a chance. That is why we are here today. And I hope we can turn away from this process and share the light of day with our colleagues and with America.

Thank you, Mr. President. I yield the floor.

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

Mr. DURBIN. Mr. President, a famous Washington figure once wrote a book entitled ''Slouching Towards Gomorrah.'' If you were to describe what is happening in the Senate procedurally, we would call it lurching toward cloture. The cloture rules in the Senate require 30 hours between votes, and as a consequence we find ourselves in the early morning hours trying to finish this bill before the Christmas holiday, and it calls for the Senate to convene at extraordinary times, as we did this morning, but it is for a good purpose.

This is to bring to a close a debate which has gone on for more than 3 weeks. You have noticed more and more Republican Senators now coming to the floor with ideas and amendments, and the obvious question we have to ask is, Where have you been? For the first 21 days of debate on this bill, the Republicans offered four substantive amendments. They offered six motions to take the bill off the floor, send it back to committee, and quit the deliberations, but only four substantive amendments. Now they say they are just brimming with all of these notions and ideas that can improve this bill. They had the chance. In fact, they had more than a chance. They were invited into this process early on.

I would say to the Senator from Texas, she knows that 3 of her colleagues met over 61 times with their Democratic counterparts trying to come up with a bipartisan approach, and they couldn't. We also know that in the Health, Education, Labor, and Pensions Committee, the Republicans came and engaged in more than 50 days of deliberations in that committee and offered and had accepted more than 150 Republican amendments to this bill. We were not excluding Republicans from the process; they excluded themselves. When it came time for a final vote in the Health, Education, Labor, and Pensions Committee, not a single Republican Senator would vote for it. Senator COBURN of Oklahoma offered and had accepted 38 amendments to this bill and wouldn't vote for it. Other Senators were the same. They had their chance, and they didn't use their chance. In fact, the record shows now that after almost a year of deliberations, we have one Republican Congressman from New Orleans, LA, who voted for the House health care reform proposal, and one Republican Senator, Ms. SNOWE of Maine, who voted for the Finance Committee proposal. To say the Republicans have been actively engaged in this process is a misstatement.

Here is why we have to go forward, even if we have to meet at 7 in the morning or even if we have to meet this Christmas week. When this bill is passed, we know from the CBO several things will occur. First, 30 million Americans who currently don't have health insurance will have the peace of mind of knowing they have health insurance. Secondly, we know 94 percent of the American people will finally be insured—the highest percentage in the history of the United States. We know the rates for health insurance premiums will start to come down, as they must, so businesses and individuals can afford it. We know that, finally, consumers across America will be able to stand and fight back when health insurance companies turn them down in their moments of need.

We say in this new amendment we are going to say to health insurance companies: You cannot deny coverage to anybody under 18, any child, for a preexisting condition. That is going to bring peace of mind to millions of American families who understand that without this they couldn't get the health insurance they absolutely need for their children.

Let me address quickly this notion that this is somehow a mystery amendment. This amendment has now been before the American public for at least 70 hours on the Internet. The bill itself has been before the American public now for more than 3 weeks on the Internet. You can find it not only on the Democratic Senate Web site, you can find it on the Republican Web site. They put our bill on their Web site because they don't have a comprehensive health care reform bill. They put ours up for people to read. There has been ample opportunity for people to read, dissect, and to be critical of it and raise questions about it. Before our final vote, America will have had its chance to read and understand the import of this effort and this effort is substantial.

This is something we have built up to for decades. To finally put the Senate on record as to whether we are endorsing the current health care system in America that is unaffordable, discriminates against people, and leaves so many behind, a system that currently rations care and says to 50 million Americans you have no coverage, and to millions of others that you have coverage that will not be there when you need it—we have to bring that to an end.

As Senator HARKIN said the other day in closing the debate, this is a real debate over whether health care will be a right or a privilege in America. If you believe it is a privilege for those who are wealthy and well off, then, of course, you will vote against this. If you believe it is a right that should be extended to more Americans, I hope you will join us in supporting it.

I yield the floor.

Mr. REID. Mr. President, has all time expired?

The ACTING PRESIDENT pro tempore. Forty seconds remain.

Mr. REID. I yield back that time.

The ACTING PRESIDENT pro tempore. The time is yielded back.

Mr. REID. Mr. President, I move to table amendment No. 3278, and I ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

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

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 386 Leg.]

YEAS—60

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

NAYS—39

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Inhofe

The motion was agreed to.

The PRESIDING OFFICER. The majority leader.

AMENDMENT NO. 3277 WITHDRAWN

Mr. REID. Mr. President, it is my understanding that the second-degree

amendment has been withdrawn; is that right?

The PRESIDING OFFICER. Under previous order, amendment No. 3277 is withdrawn.

AMENDMENT NO. 3276

Mr. REID. Mr. President, I ask for the yeas and nays on amendment No. 3276.

The PRESIDING OFFICER. The yeas and nays were previously ordered.

The question is on agreeing to amendment No. 3276.

The clerk will call the roll.

The assistant legislative clerk called the role.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

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

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 387 Leg.]

YEAS—60

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

NAYS—39

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Inhofe

The amendment (No. 3276) was agreed to.

CLOTURE MOTION

The PRESIDING OFFICER. Pursuant to rule XXII, the Chair lays before the Senate the following cloture motion which the clerk will report.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the Reid substitute amendment No. 2786 to H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher J. Dodd, Richard Durbin, Paul G. Kirk, Jr., Max Baucus, Claire McCaskill, Jon Tester, Maria Cantwell, Barbara A. Mikulski, Mark Udall, Sherrod Brown, Arlen Specter, Bill Nelson, Mark Begich, Sheldon Whitehouse, Roland W. Burris, Kirsten E. Gillibrand, Ron Wyden.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on amendment No. 2786, as amended, offered by the Senator from Nevada, Mr. REID, to H.R. 3590, the Service Members Home Ownership Tax Act of 2009, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

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

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 388 Leg.]

YEAS—60

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

NAYS—39

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Inhofe

The PRESIDING OFFICER. On this vote the ayes are 60, the nays are 39. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

The majority leader is recognized.

AMENDMENT NO. 2878

Mr. REID. Mr. President, I ask the clerk to call and report amendment No. 2878.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. CARDIN, proposes an amendment No. 2878.

Mr. REID. I ask unanimous consent the reading of the amendment be waived.

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

(The amendment is printed in the RECORD of Thursday, December 3, 2009 under ''Text of Amendments.'')

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3292 TO AMENDMENT NO. 2878

Mr. REID. I now ask the clerk to report amendment No. 3292.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 3292 to amendment No. 2878.

The amendment is as follows:

(Purpose: To change the effective date)

At the end of the amendment, insert the following:

This section shall become effective 5 days after enactment.

Mr. REID. Mr. President, it is my understanding—Senator MCCONNELL and I have agreed—I should not say I understand—we have agreed that the time until 9:30 will be equally divided and controlled between the two leaders, and at 9:30 we will go, as we have worked in recent days, into having blocks of time until our caucuses, until 12:30.

The PRESIDING OFFICER. The majority leader is correct. Under the previous order, until 9:30 the time is equally divided and controlled between the leaders or their designees, and under the previous order the time until 5:30 today will be divided into 1-hour alternating blocks of time, the majority controlling the first block.

Mr. REID. Mr. President, I ask everyone to acknowledge that we have our regular weekly caucuses at 12:30. We will come back at 2:30, and we will be going back to blocks of time until 5:30 this evening.

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

Mr. REID. Mr. President, I said when the Senate opened today and I will say again, because of the long hours we have spent here for weeks now, there is a lot of tension in the Senate. Feelings are high, and that is fine. Everybody has very strong concerns about everything we have done and have to do. But I hope everyone would go back to their gentlemanly ways. I was trying to figure out how to say this—gentlemanly ways. We used to say in the House gentlewomen, so I guess it is the same here.

Anyway I hope everyone has—I have said to a number of people—Rodney King—let's all just try to get along. That is the only way; we need to do it. This is a very difficult time in the next day or so. Let's try to work through this.

For those of the Christian faith we have the most important holiday, and that is Christmas.

I would hope everyone would keep in mind that this is a time when we reflect on peace and the good things in life. I would hope everyone would kind of set aside all the personal animosity, if they have any in the next little bit, and focus on the holiday.

The PRESIDING OFFICER. The minority leader.

Mr. MCCONNELL. Mr. President, let me add, to my good friend the majority leader, he and I have an excellent relationship. We speak a number of times in the course of every day and have no animosity whatsoever. We are working on an agreement that will give certainty to the way to end this session. Hopefully, the two of us together can be recommending something that makes sense for both sides in the not-too-distant future.

The PRESIDING OFFICER. Who yields time?

The Senator from Montana.

Mr. BAUCUS. What is the regular order?

The PRESIDING OFFICER. The time until 9:30 is equally divided between the leaders or their designees.

The Senator from Montana.

Mr. BAUCUS. Mr. President, it has been more than a month since the majority leader moved to proceed to the health care reform bill before us today. At long last, the Senate is now in the final throes of passing this historic legislation.

From the beginning, this Senator has sought out what Abraham Lincoln called ''the better angels of our nature.'' That is the way this Senator has always sought to legislate.

A year and a half ago, I convened a bipartisan retreat at the Library of Congress. Half a year ago, I convened three bipartisan roundtables with health care experts. Half a year ago, the Finance Committee conducted three bipartisan walk-throughs of the major concepts behind the bill before us today.

We went the extra mile. I reached out to my good friend, the ranking Republican member of the Finance Committee. I reached out to the ranking Republican member of the HELP Committee.

We sought to craft a bill that would appeal to the broad middle. We sought to craft a bill that could win the support of Republicans and Democrats alike.

We met, a group of six of us, three Democrats and three Republicans. We met more than 30 times. We met for months, encouraged by the President to do so. Our group met with the President several times. The President encouraged us to keep pursuing our negotiations, hoping to reach bipartisan agreements.

No, we did not reach a formal agreement. The leadership on the other side of the aisle went to great lengths to stop us from doing so.

But even though we did not reach a formal agreement, we came very close to doing so. The principles that we discussed are very much the principles upon which the Finance Committee built its bill. The principles that we discussed are very much the principles reflected in the bill before us today. Our work began much earlier than I have indicated. We met all the preceding year, held about ten hearings in the Finance Committee working toward health care reform. We also finished a white paper in November 2008. I say with trepidation that basically that is the foundation from which almost all ideas in health care reform emanated. To be fair, the ideas in that paper had been floating around, principles from the Massachusetts health care reform, for example. Most policy experts and health care economists who had been working on reform published their ideas. We sought the best, compiled them, and put together that white paper published in November of last year.

From the debate that the Senate has conducted this past month, you would not know it. During this debate, some on the other side of the aisle have mischaracterized the bill before us. Some on the other side of the aisle have set about a systematic campaign to demonize this bill.

Through bare assertion alone, with the thinnest connection to fact, they have sought to vilify our work. If one listened to their assertions alone, one would not recognize the bill before us.

And so, let me, quite simply, state the facts.

Some on the other side of the aisle assert that this bill is a government takeover of health care.

The fact is that the nonpartisan Congressional Budget Office says that this bill would reduce the government's fiscal role in health care. Just 3 days ago, CBO wrote, and I quote:

> CBO expects that the proposal would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window.

Some on the other side of the aisle assert that this bill would add to our Nation's burden of debt.

The fact is that the nonpartisan Congressional Budget Office says that this bill would reduce the deficit by $132 billion in the first 10 years and by between $650 billion and $1.3 trillion in the second 10 years. The fact is that this is the most serious deficit reduction effort in more than a decade.

Some on the other side of the aisle assert that this bill would harm Medicare.

The fact is that Medicare's independent actuary says that this bill would extend the life of Medicare by 9 years. The fact is that this is the most responsible effort to shore up Medicare in more than a decade.

Some on the other side of the aisle assert that this bill does not do enough to ensure the uninsured.

The fact is that the nonpartisan Congressional Budget Office says that this bill would extend access to health care to 31 million Americans who otherwise would have to go without. The fact is that CBO says, and I quote:

> The share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent.

Nothing that Senators on the other side of the aisle have proposed would come close. CBO estimated that the Republican substitute offered in the House of Representatives would have extended coverage to just 3 million people. The fact is that CBO says of that plan, and I quote:

> The share of legal nonelderly residents with insurance coverage in 2019 would be about 83 percent, roughly in line with the current share.

I would cite the facts about the Republican substitute in the Senate. But the fact is that there is no Republican substitute.

Some on the other side of the aisle assert that they simply prefer a more modest reform of health care.

The fact is that the Republicans controlled the Senate from 1995 to 2001 and from 2003 to 2006. The fact is that before they took control, in 1994, 36 million Americans, 15.8 percent of nonelderly Americans were without health insurance coverage. In the last year of their control, in 2006, nearly 47 million Americans, 17.8 percent of non-elderly Americans were without health insurance coverage. The legacy of Republican control was 10 million more Americans uninsured.

Some on the other side of the aisle say that we are moving too fast.

The fact is that it was 1912, when former President Theodore Roosevelt first made national health insurance part of the Progressive Party's campaign platform. The fact is that people of good will have been working at this for nearly a century.

The fact is, health care reform for America is now within reach. The fact is, the most serious effort to control health care costs is now within reach. The fact is, life-saving health care coverage for 31 million Americans is now within reach.

Let us, at long last, grasp that result. Let us, this time, not let this good thing slip through our hands. And let us, at long last, enact health care reform for all.

I suggest the absence of a quorum and ask unanimous consent that the time be charged equally to each side.

The PRESIDING OFFICER (Mr. WHITEHOUSE). Without objection, it is so ordered.

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mrs. HUTCHISON. I ask unanimous consent that the order for the quorum call be rescinded.

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

Mrs. HUTCHISON. Mr. President, are we now in a period where we go back and forth without limit?

The PRESIDING OFFICER. We are.

Mrs. HUTCHISON. Mr. President, I ask to be notified after 5 minutes, after

which Senator VITTER is going to speak.

The PRESIDING OFFICER. The Chair will so notify.

Mrs. HUTCHISON. Mr. President, we have talked a lot about what is in this bill, the massive tax increases, the massive cuts in Medicare. But there is another issue I think, looking down the road, we are going to need to pursue. We have talked about how groundbreaking this bill is. In fact, the majority calls it historic, and it is historic. We believe it is historic in the bad precedents it is setting, both in process and in substance. I think some of these precedents are going to be tested under the Constitution of the United States.

I wish to start by talking about a couple of those. No. 1, in the effort to get the last vote, clearly there were deals made. There were deals that affect individual States and even one that affects two insurance companies that will have a different treatment from all the other insurance companies in America. It is said there will be two Nebraska insurance companies that will not have to pay the tax increases of the insurance companies that will be levied on all the other health insurance companies. This is an issue that must be raised under the Constitution, the equal protection clause of the Constitution. To take a set of companies in an industry, competitors—and we value the free market system and the free enterprise system—to pluck out two competitors and say: You will be treated differently because we need your vote to pass this bill should be tested under the Constitution of the United States.

It is my hope some insurance company that has standing to bring this suit will be able to test this precedent. It is a very bad precedent, and it is certainly bad policy to start passing laws that distinguish some parts of an industry versus other parts of an industry that would be treated in a different way. I hope we will do that.

No. 2, I believe there is a 10th amendment issue. Here is my concern. Many States, including my State of Texas, have self-insurance plans for State employees. States with large numbers of State employees find that self-insurance is a better way to go than private insurance programs. In this bill, every insurance company that plans to increase its premiums must get approval from the Department of Health and Human Services first.

Now, my State of Texas, with its self-insurance plan, then, has to go to the Secretary of Health and Human Services to ask permission to increase the premiums on their State self-insured insurance plan. That is a violation of the 10th amendment, as I see it.

I am very concerned that a State that has State employees who accept a self-insurance plan would then be able to be told by the Federal Government that they cannot increase their premiums to cover the cost and keep the sound system that they have in place.

Now, other States have self-insurance plans, so I believe they would also be very affected by this, and I believe there will be a standing for a State with this type of plan to be able to challenge this part of this bill and, hopefully, bring it down if it is a violation of the 10th amendment.

I want to talk about another area that I think is a stretch in this bill; that is, apparently the individual mandate is being justified by the commerce clause of our Constitution. Now, the commerce clause basically says no State may impede interstate commerce. You may say, out in America: I don't see the connection. I am going to be mandated to buy health insurance or be fined if I don't because States cannot impede interstate commerce?

Well, I would agree with people out there that seems like a disconnect because, apparently, using the commerce clause, the majority is saying the Federal Government has the right to manage insurance, and that a requirement of an individual mandate is part of the Federal capability to manage insurance in this country, and you cannot impede that right by the Federal Government because you cannot impede interstate commerce.

I think this whole individual mandate issue is going to be a center for discussion, debate, and opposition to the bill that is clearly moving down a track that we are trying to stop, but that train is moving. I think we are going to have to talk about the individual mandate. People are saying to me: How can the Federal Government tell me I have to buy insurance? I think they have a point.

You have to buy automobile insurance because, but that comes with the right to drive. So you get the right, licensed by the State, to drive your car, and in exchange for that a State may require that you have collision insurance on your automobile, and many States do. But when you say you have to buy an insurance policy, I think that crosses a line where a person has a right to say: I am not going to buy insurance if I guarantee that I am not going to be a burden to the Federal Government or to the State government or to any other taxpayer. I think you should have that right, but that is not the way this bill is written.

The bill is a Federal mandate that every person in America has to have health insurance or be fined if they do not. So at least if we were going to write such a provision, to keep the right of an individual not to have a mandate under the commerce clause of the Constitution, at least you ought to say that a person would have to sign something that says: I will give you a promissory note if I do not choose to buy insurance. But that is not the way this bill is written.

So I think this, along with the State mandate on Medicaid—which, again, I think is an equal protection issue, and maybe that is a stretch—but that one State will not have to ever pay the State's share of the increase in Medicaid that is in this bill but the other 49 States in America will is certainly a violation of our responsibility to treat all States equally or to have formulas that have some ability to say there is a standard that has been set that should prevail. But not in this bill.

My State of Texas will have almost a $10 billion increase in its State's share of Medicaid because of the expansion in this bill. But there are States that are exempted from the increases and one State that is exempted forever because of a deal made to get that 60th vote to pass this bill.

I think people are looking at this issue in America today and saying: What has gotten into the people in Congress who are voting for this bill?

So, Mr. President——

The PRESIDING OFFICER. The Chair apologizes. The Chair did not notify the Senator at 5 minutes. The Chair forgot. The Senator's 5 minutes has passed.

Mrs. HUTCHISON. Mr. President, thank you for the notification.

I think there are issues now that will be raised going forward in the future, and there is still time for one Senator in the 60 to change the vote. Therefore, I hope one will hear from his or her constituents enough that that person will say: It is time to slow this bill down. I am going to change my vote so people can see all the effects that we have not talked about yet, and let's do this right.

We can lower the cost of health care, we can provide more access to more people to have health care coverage, which should be the goal of this legislation, this massive reform of a health care system that is working for many and has provided the best quality of health care in the world. We have a chance to keep it by slowing this bill down. That is why we are fighting. That is why we are still here talking 3 days before Christmas. We want to stop this bill and do it right. Doing it right is more important than doing it fast, and I think the American people believe that too.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Mr. President, how much time remains on the minority side before 9:30 a.m.?

The PRESIDING OFFICER. There is 24 minutes remaining on the minority side.

Mr. VITTER. Thank you, Mr. President.

Mr. President, since this latest version of comprehensive health care reform was unveiled a few days ago—a 2,733-page bill—I have been looking at it very carefully, particularly, of course, with the Louisiana perspective, and I want to share my strong concerns with that Louisiana perspective with my colleagues today.

Of course, we have all heard this Senate health care reform bill referred to

as the ''Louisiana purchase'' because of the special $300 million provision in it related to our Medicaid match rate.

Quite frankly, I do not much like that nickname for two reasons. First of all, the fact that we in Louisiana have to pay a higher Medicaid match rate under present law because of the hurricanes is a real inequity, which I support fixing. It is a shame the merits of that fix, which are very real, have been completely lost in this debate because of the way this Louisiana fix has been used and abused, quite frankly, in trying to pass this megabill.

But, secondly, I do not like the phrase because it suggests that Louisiana in general would fare very well under the bill overall, and nothing could be further from the truth. This bill overall sells Louisiana short. It sells Louisiana out. In fact, rather than the ''Louisiana purchase,'' I think the bill could be very accurately called the ''Louisiana sellout.''

What are those costs and those serious problems for Louisiana I am talking about?

Let's start with Medicaid, the program for the poor. Let's start with that $300 million fix. It is certainly true that fix is there—a $300 million benefit to the State under our Medicaid Program—but that is not all of the picture. It is not even all of the Medicaid picture because besides that fix, in the bill overall there is a dramatic expansion of Medicaid—a huge expansion—and the Louisiana State government and Louisiana taxpayers have to help pay for that expansion. That extra cost to the State government, to the State taxpayer, is way more than the $300 million benefit.

By very conservative estimates by the Louisiana Department of Health and Hospitals, it is at least $1.3 billion over 10 years of full implementation. So, sure, a $300 million benefit but, at least, minimum, a $1.3 billion cost—extra cost—to the State.

Now, three things are important about these figures. One is obvious: $300 million is a whole lot less than $1.3 billion. But, secondly, this $1.3 billion over 10 years of full implementation is a very conservative estimate from the Louisiana Department of Health and Hospitals. And, No. 3, while this money, the $300 million, is one time, this other goes on forever. This $1.3 billion is the first decade cost, but it goes on forever from there; and every 10 years, this grows and is repeated.

So what does that mean? That means in the first 10 years of full implementation, the net impact on the State is very negative, at least $1 billion, and it goes on from there.

I am very concerned about a lot of other groups in Louisiana, not just the State government and State budget. I am particularly concerned about Louisiana seniors. Of course, Louisiana seniors, like seniors everywhere, depend on Medicare. They have paid into it their whole lives. This bill—it is a simple fact; it is confirmed by the Congressional Budget Office, nonpartisan—this bill cuts Medicare $466 billion. Medicare now is already facing insolvency by 2017. So instead of fixing that in a real way, the bill steals almost $½ trillion from Medicare and uses it not within Medicare but to help pay for a brand-new entitlement.

Mr. BAUCUS. Mr. President, will the Senator yield for a question?

Mr. VITTER. I will not at this time. I will be happy to yield after my presentation.

That means real cuts in terms of hospitals, home and hospice, nursing homes, and Medicare Advantage. There are over 151,000 Louisiana seniors on Medicare Advantage. They are going to be particularly hard hit. They like that choice now. They will not have that choice as it exists now under this bill.

How about Louisiana taxpayers? I am also very concerned about Louisiana taxpayers. Again, according to the nonpartisan Congressional Budget Office, the bill contains $518 billion of tax increases nationwide—over $½ trillion of tax increases. As for that oft repeated promise that no one who earns under $200,000 will be affected, well, again, think again. The Joint Committee on Taxation—nonpartisan—has said 42.1 million Americans earning below $200,000 will get a tax increase over the next several years—42.1 million. That means hundreds of thousands of Louisiana taxpayers will be hit, will get a tax increase—I am talking about folks who earn well below $200,000—will also pay more in the form of higher insurance premiums because, again, the nonpartisan Congressional Budget Office has said this bill increases overall health care costs. It does not decrease those costs.

Well, what about Louisiana small businesses? Surely, this bill protects them in the midst of this serious recession. Well, not exactly. The biggest impact on businesses is a brandnew mandate in the bill. Most businesses have to either provide a government-defined health insurance benefit or they have to pay a new tax to the government. NFIB, the National Federation of Small Business, says that is going to cost the Nation 1.6 million jobs. Translated to Louisiana, that is tens of thousands of additional lost jobs on top of our current high unemployment. Again, we are in the middle of a serious recession. This will cost us jobs on top of that.

There is also another big problem, which is an incentive for businesses to drop coverage. I mentioned that brandnew mandate: Either you provide a government-defined health benefit or you pay a new tax to the Federal Government. The other problem with that is, for a lot of business, it is going to be cheaper to drop coverage and pay the new tax. So many employees who have coverage now that they are reasonably satisfied with are going to lose it, and that is a big concern as well.

Just for good measure, the bill forces pro-life taxpayers to, in many very meaningful ways, subsidize abortion. Louisiana is one of the most proudly pro-life States in the Nation, so that is particularly offensive. Everyone who cares about life, who has followed this issue, whether it is the Catholic Bishops, National Right to Life, and other organizations have said, clearly, the language in this bill doesn't protect against taxpayer-funded abortion. The language in this bill does not honor the Hyde amendment, which has been Federal law since 1977. The language in this bill crosses an important line, does not offer the conscience protections we have depended on for years. So this sets radical new precedent in terms of taxpayer and Federal Government support of abortion. That is a big Louisiana concern as well.

So what do we have? We have a 2,733-page bill, mega health care reform, with all these very serious problems for Louisiana and important Louisiana groups and important Louisiana citizens, including seniors, small business, taxpayers, and the State budget, which is already facing serious cuts and challenges.

If we want to put Louisiana first considering all these costs, we have to say no to this bill. If we want to put America first considering all these unsustainable costs, we have to say no to this bill. But we can and we should say yes to the right kind of health care reform. This isn't a debate about yes or no, health care reform or not; this is a debate about what the right kind of health care reform is.

To me, we need to start over with that right kind of reform. To me, that would mean something such as starting by passing five bills. Each one doesn't need to be longer than 25 pages. Each one would be focused like a laser beam on a real problem that affects real Louisianans, real Americans, offering a real, concrete, focused solution. My five bills would be this: Cover preexisting conditions. That is a real problem in Louisiana. That is a real problem in America. Let's have a focused bill that does that.

Secondly, allow buying insurance across State lines. That would dramatically expand competition in the marketplace. That would lower premiums. That would give all folks wanting health insurance dramatically decreased costs than they have now.

Third: Let's do something real about prescription drug prices. Let's not sell out to PhRMA and cut a special deal with the pharmaceutical industry, as the White House has. Let's pass reimportation and pass real generics reform.

Fourth: Let's pass tort reform and take all that unnecessary cost out of the system. That doesn't provide better health care for anyone. It doesn't do anything positive for anyone except wealthy trial lawyers. Let's pass tort reform.

And fifth: Let's allow small business to pool across State lines to form larger pools of insurance across State lines

and gain from that extra buying power. Why shouldn't a restaurant in Baton Rouge that may only have seven or eight people to cover in health insurance, why shouldn't they be able to pool through the National Restaurant Association, create a pool of millions nationwide and enjoy the same buying power Apple Computers or Toyota has and get the same benefit in the insurance marketplace through that increased buying power and increased competition?

So I urge all my colleagues to put their State first and vote no, to put our Nation first and vote no, and to start anew with the right sort of focused reform as I have outlined.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I just have a couple statements to make, points to make, in view of the last statement, to correct some misimpressions given by the last statement.

The last speaker said Medicare cuts apply and this is going to cut Medicare. The fact is—I wish the previous speaker would stay on the floor, but he is fleeing the floor because he knows I am going to mention facts in total refutation to the assertions he is making. He leaves the floor. He will not stay with me to talk about what is going on. He makes statements that are misrepresentations and then he leaves the floor.

Let me talk about some of the things he said which are incorrect. One, he basically says Medicare is going to be hurt by these huge cuts to Medicare. The fact is, we are helping the Medicare trust fund with this legislation. The fact is, the Chief Actuary at HHS has said this legislation before us will increase the solvency of the Medicare trust fund another 9 years. That is a fact.

Second, he is trying to say there are a lot of big tax increases here. He is trying to direct the public away from what the fact is. The fact is, the Joint Committee on Taxation says there are $436 billion of tax cuts in this legislation, reductions in taxes; $436 billion in tax cuts in the form of tax credits for people who purchase insurance in the exchange. It is a tax cut of $436 billion of tax cuts in the exchange. I might say $40 billion of that is small business tax cuts. They are not increases, they are tax cuts for small business and the tax cuts for individuals is $436 billion.

Frankly, I wish I had a lot of the data before me. I don't have it right now to refute other points he made. He talked about premiums going up. The Congressional Budget Office basically says 93 percent of Americans will find their premiums will come down because of this legislation, and for a certain class of individuals—those in the individual market and the small group market will get very significant reductions in premiums on account of this bill.

It irritates me, frankly, when Senators come to the floor and make all these misstatements and they are not based at all on fact.

In fact, what we need to do around here is get more and more institutions to objectively analyze policy so we know what the facts are. It is pretty hard to argue the facts. The CBO does a pretty good job. The Joint Committee on Taxation does a pretty good job. But if somehow this country could turn to an organization or organizations to find the facts—just the facts—I think it would help a little bit because it is hard to argue the facts. If you have good facts, you generally can create good policy.

Back to premiums. CBO says 93 percent of premiums go down. Actually, for about five-sixths of those insured—that is, those who work for larger companies, it is called the large group markets—premiums will go down not a lot but a little. According to CBO, it is up to a 3-percent reduction in premiums. They look at the year 2016 as a benchmark year, so CBO says that for those, about 70 percent of Americans who work for large markets, premiums will actually go down 3 percent.

What about 13 percent of Americans who work for small groups, small companies? Basically, CBO and the Joint Committee on Taxation say those could go up 1 percentage point as well as down 2 percentage points. It is about even. It is difficult to tell. But those who get credits in the small group market will find their premiums down by about 8 to 11 percent. Those who work for small companies will find their premiums go down 8 to 11 percent.

What about the nongroup market—individuals. Well, basically, if you compare today's insurance premiums with what it might be in the future, the premiums will go down 14 to 20 percent, but because of better benefits, premiums could go up 10 to 13 percent for 7 percent of Americans. As I mentioned earlier, 93 percent will find their premiums go down. For 7 percent they will go up, but for those 7 percent, they are going to have a lot better coverage, a lot better insurance in 2016. All the insurance market reforms will have kicked in: denial of preexisting conditions, market status, health status and so on and so forth.

Get this: For the nongroup market, 17 percent of Americans who buy insurance through the nongroup market, 10 percent of that 17 percent, because of tax credits, will find their premiums go down by—guess how much—56 to 59 percent. Once more: 17 percent of Americans buy insurance individually. Of those 17 percent, 10 percent of them will find their premiums will be reduced 56 to 59 percent. That is according to the Joint Committee on Taxation. Only one small group, according to the Joint Committee on Taxation, will find an increase in 2016. That is 7 percent of Americans in 2016, but that will be compensated with a lot better insurance, high-quality insurance. No more rescissions. No more denial based on preexisting conditions. The rating reforms will have kicked in and the annual limits, the lifetime limits will have been repealed. It will be a heck of a lot better insurance. So maybe their premiums will go up a little bit, but they will get a heck of a lot better buy for what they are getting. It is similar to buying a new car instead of a used car—hopefully, a good new car. All in all, in a very real sense, all Americans are going to find his or her premiums will go down. Seven percent will find them go up a little bit, but they will get a heck of a lot better insurance for the premiums they will be paying.

The previous speaker is wrong when he says it will increase premiums. The Joint Committee on Taxation says it will not. I didn't hear him quote the Joint Committee on Taxation saying premiums will go up. If you look at the actual analysis by the Joint Committee on Taxation, they find the premiums will go down.

Seeing nobody who wishes to speak, I wish to address the question of the constitutionality of the individual mandate. Let me read into the RECORD an analysis by Mark Hall, prepared by the O'Neill Institute. Basically, he says the following:

Health insurance mandates have been a component of many recent health care reform proposals. Because a Federal requirement that individuals transfer money to a private party is unprecedented, a number of legal issues must be examined. This paper analyzes whether Congress can legislate a health insurance mandate and the potential legal challenges that might arise given such a mandate. The analysis of legal challenges to health insurance mandates applies to federal individual mandates, but can also apply to a federal mandate requiring employers to purchase health insurance for their employees. There are no constitutional barriers for Congress to legislate a health insurance mandate as long as the mandate is properly designed and executed as discussed below. This paper also considers the likelihood of any change in the current judicial approach to these legal questions.

Potential solutions. Congress's Authority to Regulate Commerce: The federal government has the authority to legislate a health insurance mandate under the Commerce Clause of the United States Constitution. A federal mandate to purchase health insurance is well within the breadth of Congress's power to regulate interstate commerce. Congress can avoid legal challenges related to the 10th Amendment and states' rights by preempting state insurance laws and implementing the mandate on a Federal level. If Congress wants states to implement a federal mandate, it has the following two options:

Conditional Spending: Congress may condition federal funding, such as that for Medicaid or public health, on state compliance with federal initiatives. Conditional Preemption: Congress may allow states to opt out of complying with direct federal regulation as long as states implement a similar regulation that meets Federal requirements.

Congress's Authority to Tax and Spend for the General Welfare: Congress also has the authority to legislate a health insurance mandate under its Constitutional authority to tax and spend.

There are no plausible Tenth Amendment and states' rights issues arising from Congress's taxing and spending power. However, Congress's taxation power cannot be

used in a way that burdens a fundamental right recognized in the Constitution's Bill of Rights and judicial interpretations by the U.S. Supreme Court. Since there is no fundamental right to be uninsured, no fundamental right challenge exists.

Other Relevant Constitutional Rights: Challenges under the First and Fifth Amendments relating to individual rights may rise, but are unlikely to succeed. The federal government should include an exemption on religious grounds to a health insurance mandate as an added measure of protection from legal challenges based on religious freedom. In the alternative, the federal government can simply exempt a federal insurance mandate from existing federal legislation protecting religious freedom.

Considerations: To avoid a heightened level of security in any judicial review, the federal government should articulate its substantive rationale for mandating health insurance during the legislative process.

It goes on, and it is probably too lengthy to read. Professor Hall wrote this. He is a professor at Wake Forest University.

I will read the conclusion:

The Constitution permits Congress to legislate a health insurance mandate. Congress can use its Commerce Clause powers or its taxing and spending powers to create such a mandate. Congress can impose a tax on those who do not purchase insurance, or provide tax benefits to those that do purchase insurance. . . . If Congress would like the States to implement an insurance mandate, it can avoid conflicts with the anti-commandeering principle by either preempting state insurance laws or by conditioning federal funds on State compliance. A federal employer mandate for state and local government workers may be subject to a challenge; however, such a challenge is unlikely to be successful. Individual rights challenges under the First Amendment's Free Exercise Clause or RFRA are unlikely to succeed, although a federal insurance mandate should include a statement that RFRA does not apply or provide for a religious exemption. Fifth Amendment Due Process and Takings Clause challenges are also unlikely to be successful. A legal analysis presented is likely to endure, as the Supreme Court's current position and approach to interpreting relevant constitutional issues appear to be stable.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. BURRIS. Mr. President, as this debate draws to a close and my colleagues and I prepare to vote on a health care reform bill, I recognize that long hours and tense negotiations have left some nerves and tempers frayed. That is why I come to the floor.

Although our work keeps us away from our family and friends for much of this holiday season, I see no reason why we cannot share good cheer with one another right here in Washington.

So in the spirit of the season, I would like to share my own version of a classic holiday story with my good friends on both sides of the aisle.

It goes something like this:

'Twas the night before Christmas and all through the Senate
The Right held up our health bill, no matter what was in it.
The people had voted—they mandated reform—
But Republicans blew off the gathering storm.
''We'll clog up the Senate!'' they cried with a grin,
''And in midterm elections, we'll get voted in!''
They knew regular folks need help right this second—
But fundraisers, lobbyists and politics beckoned.
So, try as they might, Democrats could not win
Because their majority was simply too thin.
Then, across every State there arose such a clatter
The whole Senate rushed out to see what was the matter!
All sprang up from their desks and ran from the floor
Straight through the cloakroom, and right out the door.
And what in the world could be quite this raucous?
But a mandate for change! From the Democratic caucus!
The President, the Speaker, and of course Leader Reid
Had answered the call in our hour of need.
More rapid than eagles the provisions they came,
And they whistled, and shouted, and called them by name:
''Better coverage! Cost savings! A strong public plan!
Accountable options? We said 'yes we can!'
''No exclusions or changes for pre-existing conditions! Let's pass a bill that restores competition!''
The Democrats all came together to fight for the American people, that Christmas Eve night.
And then, in a twinkle, I heard under the dome—the rollcall was closed! It was time to go home.
Despite the obstructionist tactics of some, the filibuster had broken—the people had won!
A good bill was ready for President Obama, ready to sign, and end health care drama.
And Democrats explained, as they drove out of sight: ''Better coverage for all, even our friends on the right!''

And I say to all of my colleagues: In this season, Merry Christmas and a happy, happy New Year.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, in a little while, I will be making a constitutional point of order against the substitute amendment. I won't make that now because we are working on an agreement on when we can have that vote.

I want to start talking about the reason I believe this substitute amendment is unconstitutional—the individual mandate contained in it. I will be speaking for about 10 minutes now, and then I will resume my remarks at 9:30, after one of the Democrats comes down and uses their 15 minutes.

If this constitutional point of order is rejected and the health care reform bill is passed, I believe the Court should reject it on constitutional grounds.

Some of my colleagues may not be aware of the Finance Committee's debate on the constitutionality of this health care reform bill. During the committee markup of its version of the bill, Senator HATCH raised some thought-provoking constitutional questions. He offered an amendment, which I supported, to provide a process for the courts to promptly consider any constitutional challenge to the Finance Committee bill. He chose the same language that was put into the bipartisan Campaign Reform Act. Unfortunately, the amendment was deemed nongermane.

I am seriously concerned that the Democrats' health care reform bill violates the Constitution of these United States. As part of comprehensive health care reform, the Democrats would require every single American citizen to purchase health insurance. Americans who fail to buy health insurance that meets the minimum requirements would be subject to a financial penalty. This provision can be found in section 1501 of the Democrats' health care reform bill. It is called the ''requirement to maintain minimal essential coverage.''

While this is a constitutional point of order, I feel it is important to note that in the Declaration of Independence, America's Founding Fathers provided that:

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness.

What happened to life, liberty, and the pursuit of happiness? I guess Americans can only have them if they comply with this new bill and buy a bronze, silver, gold, or platinum health insurance program.

America's Founders and subsequent generations fought dearly for the freedoms we have today.

I question the appropriateness of this bill and specifically the constitutionality of this individual mandate. Is it really constitutional for this body to tell all Americans they must buy health insurance coverage? If so, what is next? What personal liberty or property will Congress seek to take away from Americans next? Will we consider legislation in the future requiring every American to buy a car, to buy a house, or to do something else the Federal Government wants?

My friend and colleague, Senator HATCH, raised similar questions during the debate in the Finance Committee. In fact, he raised the following question:

If we have the power simply to order Americans to buy certain products, why did we need a cash for clunkers program, or the upcoming program providing rebates for purchasing energy efficient appliances? We can simply require Americans to buy certain cars, dishwashers, or refrigerators.

Where do we draw the line? Will we even draw one at all? The Constitution draws that line. It is called the enumerated powers. I don't think Congress has ever required Americans to buy a product or service, such as health insurance, under penalty of law. I doubt Congress has the power to do that in the first place.

As the CBO explained during the 1990s:

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 any good or service as a condition of lawful residence in the United States.

Yet that is exactly what this health care bill would do. This bill would require Americans to buy a product many of them do not want or simply cannot afford.

Some individuals have raised the example of car insurance in the context of this debate. But requiring someone to have car insurance for the privilege of being able to drive is much different from requiring someone to have health insurance. As Senator HATCH pointed out, people who do not drive do not have to buy car insurance. Senator HATCH is right. If you live in New York City, you probably rely on subways or some other form of mass transit. You probably do not own a car, so you have no reason to buy car insurance and you are not forced to do so. Yet this health care reform bill requires Americans to buy health insurance whether or not they ever visit a doctor, get a prescription, or have an operation.

Under this bill, if you do not buy health insurance coverage, you will be subject to a penalty. Let's call this penalty what it really is—a tax. Even worse, this penalty operates more like a taking than an ordinary tax. If an American chooses not to buy minimal essential health coverage, he or she will face rapidly increasing taxes—up to $750 or 2 percent of taxable income, whichever is greater, by the year 2016. There is no penalty for Americans who qualify for hardship or religious exemptions. There is also no penalty for illegal immigrants or prisoners.

Americans typically pay taxes on a product or service they buy or on income they earn. For example, if you fill up your car at the pump, you pay a gas tax. If you earn income, you pay an income tax. Yet this bill creates a new tax on Americans who choose not to buy a service. It is very counterintuitive. This bill taxes Americans for not doing anything at all, other than just existing. This penalty is assessed through the Internal Revenue Code.

Senator HATCH made the following statement:

If this is a tax at all, it is certainly not an excise tax. Instead, it is a direct tax. While the Constitution requires that excise taxes must be uniform throughout the United States, it requires that direct taxes must be apportioned among the States by population. Just as the excise tax on high premiums is not uniform, this direct tax on individuals who do not purchase health insurance is not apportioned.

I recognize that the authors of this health reform bill included an individual mandate in this bill based on the idea that health care costs would be spread among all Americans and would ultimately reduce their health insurance costs. The claim is, insurance costs will be lowered because cost shifting will be reduced. This cost shift arguably takes place because health care providers—doctors and hospitals—who provide free or uncompensated care to the uninsured, shift the cost to the insured or paying patients. The hospital or doctor then shifts the cost of that unpaid care to the insured patient in the form of higher charges in order to cover the cost of uninsured patients.

I understand this concept, but I am incredibly concerned that the individual mandate provision takes away too much freedom and choice from Nevadans and from Americans across the country.

I have read and studied multiple articles by scholars on the constitutionality of the individual mandate. I believe the individual mandate provision in this health care reform bill calls into question several provisions of the Constitution. I think the Congress does not have the authority, under the enumerated powers, to enact such a mandate.

I know the supporters of the individual mandate have claimed the commerce clause and the taxes and general welfare clause in article I, section 8 of the Constitution provide authority for Congress to enact such a mandate. I wholeheartedly disagree with that assessment.

According to the Constitution, the Federal Government only has limited powers. Although the Supreme Court has upheld some far-reaching regulations of economic activity—most notably in Wickard v. Filburn and Gonzales v. Raich—neither case supports enacting the independent health insurance mandate based on the commerce clause. In these cases, the court held that Congress was allowed to regulate intrastate economic activity as a means to regulate interstate commerce in fungible goods. The mandate to purchase health insurance, however, is not proposed as a means to regulate interstate commerce, nor does it regulate or prohibit activity in either the health insurance or the health care industry.

The mandate to purchase health insurance does not purport to regulate or prohibit activity of any kind, whether economic or noneconomic. Instead, the individual mandate provision regulates no action. It purports to regulate inactivity by converting the inactivity of not buying insurance into commercial activity. In effect, advocates of the individual mandate contend that under congressional power to ''regulate commerce . . . among the several states'' Congress may reach the doing of nothing at all.

In recent years, the Supreme Court has invalidated two congressional statutes that attempted to regulate noneconomic activities. To uphold the individual mandate based on the commerce clause, the Supreme Court would have to concede that the commerce clause provides unlimited authority to regulate. This is a position that the Supreme Court has never affirmed and that it rejected in recent cases.

Congress lacks the authority to regulate the individual's decision not to purchase a service or enter into a contract. Similarly, Congress cannot rely on its power to tax to justify imposing the individual mandate.

In addition to being beyond the scope of Congress' enumerated powers, this individual mandate also amounts to a taking under the fifth amendment takings clause. I would like to take a moment to read the relevant parts of the fifth amendment. It says in part:

No person shall be . . . deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Let me repeat the part of the fifth amendment that applies to the issue at hand. It says:

. . . nor shall private property be taken for public use, without just compensation.

The bill before us today would require an American citizen to devote a portion of income—his or her private property—to health insurance coverage. There is an exception, of course, for religious reasons and for financial hardships.

If one of my constituents in Nevada does not want to spend his or her hard-earned income on health insurance coverage and would prefer to spend it on something else, such as rent or a car payment, this requirement could be a taking of private property under the fifth amendment.

As noted in a recent article coauthored by Dennis Smith and the former Deputy General Counsel of the Department of Health and Human Services, Peter Urbanowicz, requiring a citizen to purchase health insurance ''could be considered an arbitrary and capricious 'taking' no matter how many hardship exemptions the federal government might dispense.''

Some of my colleagues may also be familiar with David B. Rivkin and Lee A. Casey. They are attorneys, based in Washington, DC, who served in the Department of Justice during the Reagan and Bush administrations. In September, Rivkin and Casey published an op-ed in the Wall Street Journal entitled: ''Mandatory Insurance is Unconstitutional.'' I urge my colleagues to read this article and many others I will be submitting for the RECORD.

Mr. President, I ask unanimous consent to have printed in the RECORD at the conclusion of my remarks this Wall Street Journal by David B. Rivkin, Jr., and Lee A. Casey.

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

(See exhibit 1.)

Mr. ENSIGN. In the op-ed, Rivkin and Casey argue that the health insurance mandate:

. . . would expand the federal government's authority over individual Americans to an unprecedented degree. It is also profoundly unconstitutional.

Continuing the quote:

Making healthy young adults pay billions of dollars in premiums into the national health-care market is the only way to fund universal coverage without raising substantial new taxes.

In effect, this mandate would be one more giant, cross-generational subsidy—imposed on generations who are already stuck with the bill for the federal government's prior spending sprees.

A ''tax'' that falls exclusively on anyone who is uninsured is a penalty beyond Congress's authority. If the rule were otherwise, Congress could evade all constitutional limits by ''taxing'' anyone who doesn't follow an order of any kind.

As the fourth Chief Justice of the Supreme Court, John Marshall, stated:

The power to tax involves the power to destroy.

Unfortunately, this could certainly be true in the context of this health bill.

We in Congress must zealously defend our citizens' rights and prevent this from happening. I believe the legislation before us violates the greatest political document in the history of the world, the Constitution of the United States.

I urge my colleagues to think very carefully about the constitutional issues I have raised. I know most people around here do not like to talk about whether something is constitutional. We just want to do what feels good because we think we are helping people. But our Founders set forth in the enumerated powers limits on what this body and this Federal Government could do.

As Members of Congress, one of our most important responsibilities is to protect, to defend, and preserve the Constitution of the United States. In that light, it is not only appropriate but essential for this body to question whether it is constitutional for the Federal Government to require Americans to buy health insurance coverage.

We should also question whether it is constitutional for the Federal Government to tell Americans what kind of health insurance coverage they have to purchase. So not only does this bill tell them they have to buy health insurance, it tells Americans what kind of health insurance must be purchased.

Americans also deserve to know how the bill will impact their ability to choose the health insurance coverage that best fits their needs. That is exactly why I will raise this constitutional point of order. Freedom and choice are very precious rights. Let's not bury our heads in the sand and take away freedom and choice from American citizens. We need to think about this individual mandate very carefully.

I have several articles, and I would like to read a couple of quotes from these articles. The first one is from the Washington Post. The article is entitled, ''Illegal Health Reform.'' It is written by David Rivkin and Lee A. Casey. It says:

The otherwise uninsured would be required to buy coverage, not because they were even tangentially engaged in the ''production, distribution or consumption of commodities,'' but for no other reason than people without health insurance exist. The federal government does not have the power to regulate Americans simply because they are there. Significantly, in two cases, United States v. Lopez (1995) and United States v. Morrison (2000), the Supreme Court specifically rejected the proposition that the commerce clause allowed Congress to regulate noneconomic activities merely because, through a chain of causal effects, they might have an economic impact. These decisions reflect judicial recognition that the commerce clause is not infinitely elastic and that, by enumerating its powers, the framers denied Congress the type of general police power that is freely exercised by the states.

Mr. President, to read further from the article in the Washington Post:

Like the commerce power, the power to tax is the Federal Government's vast authority over the public, and it is well settled that Congress can impose a tax for regulatory rather than purely revenue-raising purposes. Yet Congress cannot use its power to tax solely as a means of controlling conduct that it could not otherwise reach through the commerce clause or any other constitutional provision. In the 1922 case Bailey v. Drexel Furniture, the Supreme Court ruled that Congress could not impose a ''tax'' to penalize conduct (the utilization of child labor) it could not also regulate under the commerce clause. Although the court's interpretation of the commerce power's breadth has changed since that time, it has not repudiated the fundamental principle that Congress cannot use a tax to regulate conduct that is otherwise indisputably beyond its regulatory power.

Of course, these constitutional impediments can be avoided if Congress is willing to raise corporate and/or income taxes enough to fund fully a new national health system. Absent this politically dangerous—and therefore unlikely—scenario, advocates of universal health coverage must accept Congress' power, like that of the other branches, has limits. These limits apply regardless of how important the issue may be, and neither Congress nor the president can take constitutional short cuts. The genius of our system is that, no matter how convinced our elected officials may be that certain measures are in the public interest, their goals can be accomplished only in accord with the powers and processes the Constitution mandates, processes that inevitably make them accountable to the American people.

I want to read from another article that was written by Randy Barnett, Nathaniel Stewart, and Todd Gaziano. This article is entitled, ''Why the Personal Mandate to Buy Health Insurance is Unprecedented and Unconstitutional.''

Members of Congress have the responsibility, pursuant to their oath, to determine the constitutionality of legislation independently of how the Supreme Court has ruled or may rule in the future. But Senators and Representatives also should know that, despite what they have been told, the health insurance mandate is highly vulnerable to challenge because it is, in truth, unconstitutional. And all other considerations aside, the highest obligation of each Member of Congress is fidelity to the Constitution.

I ask unanimous consent to have printed in the RECORD, following my remarks, the articles I have before me.

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

(See exhibit No. 2.)

Mr. ENSIGN. Continuing to quote, Mr. President, from the Barnett, Stewart, and Gaziano article:

A long line of Supreme Court cases establishes that Congress may regulate three categories of activity pursuant to the commerce power. These categories were first summarized in Perez v. United States, and most recently reaffirmed in Gonzalez v. Raich. First, Congress may regulate the channels of interstate or foreign commerce such as the regulation of steamship, railroad, highway or aircraft transportation or prevent them from being misused, as, for example, the shipment of stolen goods or of persons who have been kidnapped. Second, the commerce power extends to protecting ''the instrumentalities of interstate commerce,'' as, for example, the destruction of an aircraft, or persons or things in commerce, as, for example, thefts from interstate shipments. Third, Congress may regulate economic activities that ''substantially affect interstate commerce.''

Under the first prong of its Commerce Clause analysis, the Court asks whether the class of activities regulated by the statute falls within one or more of these categories. Since an individual health insurance mandate is not even arguably a regulation of a channel or instrumentality of interstate commerce, it must either fit in the third category or none at all. . . . The Senate bill asserts (erroneously) that: ''[t]he individual responsibility requirement . . . is commercial and economic in nature, and substantially affects interstate commerce. . . . The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.''

That is within the bill.

Continuing to quote:

The second prong of the Court's Commerce Clause analysis requires a determination that a petitioner has in fact engaged in the regulated activity, making him or her a member of the regulated class. In its modern Commerce Clause cases, the Supreme Court rejects the argument that a petitioner's own conduct or participation in the activity is, by itself, either too local or too trivial to have a substantial effect on interstate commerce. Rather, the Court has made clear that, ''where the class of activities is regulated and that class is within the reach of federal power, the courts have no powers 'to excise, as trivial, individual instances' of the class.'' Thus, for example, a potential challenger of the proposed mandate could not argue that because her own decision not to purchase the required insurance would have little or no effect on the broader market, the regulation could not be constitutionally applied to her. The Court will consider the effect of the relevant ''class of activity,'' not that of any individual member of the class.

To assess the constitutionality of a claim of power under the Commerce Clause, the primary question becomes, ''what class of activity is Congress seeking to regulate?'' Only when this question is answered can the Court assess whether that class of activity substantially affects interstate commerce. Significantly, the mandate imposed by the pending bills does not regulate or prohibit the economic activity of providing or administering health insurance. Nor does it regulate or prohibit the economic activity of providing health care, whether by doctors, hospitals, pharmaceutical companies, or other entities engaged in the business of providing a medical good or service. Indeed, the health care mandate does not purport to regulate or prohibit activity of any kind, whether economic or noneconomic. To the contrary, it purports to ''regulate'' inactivity.

In other words, not buying health insurance. Continuing once again:

Proponents of the individual mandate are contending that, under its power to ''regulate commerce . . . among the several states,'' Congress may regulate the doing of nothing at all! In other words, the statute purports to convert inactivity into a class of activity. By its own plain terms, the individual mandate provision regulates the absence of action. To uphold this power under its existing doctrine, the Court must conclude that an individual's failure to enter into a contract for health insurance is an activity that is ''economic'' in nature—that is, it is part of a ''class of activity'' that ''substantially affects interstate commerce.''

Never in this Nation's history has the commerce power been used to require a person who does nothing to engage in economic activity.

Let me repeat that. ''Never in this Nation's history has the commerce power been used to require a person who does nothing to engage in economic activity.''

Let me close with this because I see the senior Senator from Utah is on the Senate floor, and he has argued eloquently on the unconstitutionality of this particular provision.

Again, I am quoting:

Today, even voting is not constitutionally mandated. But if this precedent is established—

That is the precedent in this bill is established—

Congress would have the unlimited power to regulate, prohibit, or mandate any or all activities in the United States. Such a doctrine would abolish any limit on federal power and alter the fundamental relationship of the national government to the states and the people. For this reason it is highly doubtful that the Supreme Court will uphold this assertion of power.

Mr. President, I reserve the remainder of my time, and I yield to the senior Senator from Utah.

EXHIBIT 1

[From the Wall Street Journal, Sept. 18, 2009]

MANDATORY INSURANCE IS UNCONSTITUTIONAL

(By David B. Rivkin, Jr. and Lee A. Casey)

Federal legislation requiring that every American have health insurance is part of all the major health-care reform plans now being considered in Washington. Such a mandate, however, would expand the federal government's authority over individual Americans to an unprecedented degree. It is also profoundly unconstitutional.

An individual mandate has been a hardy perennial of health-care reform proposals since HillaryCare in the early 1990s. President Barack Obama defended its merits before Congress last week, claiming that uninsured people still use medical services and impose the costs on everyone else. But the reality is far different. Certainly some uninsured use emergency rooms in lieu of primary care physicians, but the majority are young people who forgo insurance precisely because they do not expect to need much medical care. When they do, these uninsured pay full freight, often at premium rates, thereby actually subsidizing insured Americans.

The mandate's real justifications are far more cynical and political. Making healthy young adults pay billions of dollars in premiums into the national health-care market is the only way to fund universal coverage without raising substantial new taxes. In effect, this mandate would be one more giant, cross-generational subsidy—imposed on generations who are already stuck with the bill for the federal government's prior spending sprees.

Politically, of course, the mandate is essential to winning insurance industry support for the legislation and acceptance of heavy federal regulations. Millions of new customers will be driven into insurance-company arms. Moreover, without the mandate, the entire thrust of the new regulatory scheme—requiring insurance companies to cover pre-existing conditions and to accept standardized premiums—would produce dysfunctional consequences. It would make little sense for anyone, young or old, to buy insurance before he actually got sick. Such a socialization of costs also happens to be an essential step toward the single payer, national health system, still stridently supported by large parts of the president's base.

The elephant in the room is the Constitution. As every civics class once taught, the federal government is a government of limited, enumerated powers, with the states retaining broad regulatory authority. As James Madison explained in the Federalist Papers: ''[I]n the first place it is to be remembered that the general government is not to be charged with the whole power of making and administering laws. Its jurisdiction is limited to certain enumerated objects.'' Congress, in other words, cannot regulate simply because it sees a problem to be fixed. Federal law must be grounded in one of the specific grants of authority found in the Constitution.

These are mostly found in Article I, Section 8, which among other things gives Congress the power to tax, borrow and spend money, raise and support armies, declare war, establish post offices and regulate commerce. It is the authority to regulate foreign and interstate commerce that—in one way or another—supports most of the elaborate federal regulatory system. If the federal government has any right to reform, revise or remake the American health-care system, it must be found in this all-important provision. This is especially true of any mandate that every American obtain health-care insurance or face a penalty.

The Supreme Court construes the commerce power broadly. In the most recent Commerce Clause case, Gonzales v. Raich (2005), the court ruled that Congress can even regulate the cultivation of marijuana for personal use so long as there is a rational basis to believe that such ''activities, taken in the aggregate, substantially affect interstate commerce.''

But there are important limits. In United States v. Lopez (1995), for example, the Court invalidated the Gun Free School Zones Act because that law made it a crime simply to possess a gun near a school. It did not ''regulate any economic activity and did not contain any requirement that the possession of a gun have any connection to past interstate activity or a predictable impact on future commercial activity.'' Of course, a health-care mandate would not regulate any ''activity,'' such as employment or growing pot in the bathroom, at all. Simply being an American would trigger it.

Health-care backers understand this and—like Lewis Carroll's Red Queen insisting that some hills are valleys—have framed the mandate as a ''tax'' rather than a regulation. Under Sen. Max Baucus's (D., Mont.) most recent plan, people who do not maintain health insurance for themselves and their families would be forced to pay an ''excise tax'' of up to $1,500 per year—roughly comparable to the cost of insurance coverage under the new plan.

But Congress cannot so simply avoid the constitutional limits on its power. Taxation can favor one industry or course of action over another, but a ''tax'' that falls exclusively on anyone who is uninsured is a penalty beyond Congress's authority. If the rule were otherwise, Congress could evade all constitutional limits by ''taxing'' anyone who doesn't follow an order of any kind—whether to obtain health-care insurance, or to join a health club, or exercise regularly, or even eat your vegetables.

This type of congressional trickery is bad for our democracy and has implications far beyond the health-care debate. The Constitution's Framers divided power between the federal government and states—just as they did among the three federal branches of government—for a reason. They viewed these structural limitations on governmental power as the most reliable means of protecting individual liberty—more important even than the Bill of Rights.

Yet if that imperative is insufficient to prompt reconsideration of the mandate (and the approach to reform it supports), then the inevitable judicial challenges should. Since the 1930s, the Supreme Court has been reluctant to invalidate ''regulatory'' taxes. However, a tax that is so clearly a penalty for failing to comply with requirements otherwise beyond Congress's constitutional power will present the question whether there are any limits on Congress's power to regulate individual Americans. The Supreme Court has never accepted such a proposition, and it is unlikely to accept it now, even in an area as important as health care.

EXHIBIT 2

[From the Washington Post, Aug. 22, 2009]

ILLEGAL HEALTH REFORM

(By David B. Rivkin, Jr. and Lee A. Casey)

President Obama has called for a serious and reasoned debate about his plans to overhaul the health-care system. Any such debate must include the question of whether it is constitutional for the federal government to adopt and implement the president's proposals. Consider one element known as the ''individual mandate,'' which would require every American to have health insurance, if not through an employer then by individual purchase. This requirement would particularly affect young adults, who often choose to save the expense and go without coverage. Without the young to subsidize the old, a comprehensive national health system will not work. But can Congress require every American to buy health insurance?

In short, no. The Constitution assigns only limited, enumerated powers to Congress and none, including the power to regulate interstate commerce or to impose taxes, would support a federal mandate requiring anyone who is otherwise without health insurance to buy it.

Although the Supreme Court has interpreted Congress's commerce power expansively, this type of mandate would not pass muster even under the most aggressive commerce clause cases. In Wickard v. Filburn (1942), the court upheld a federal law regulating the national wheat markets. The law was drawn so broadly that wheat grown for consumption on individual farms also was regulated. Even though this rule reached purely local (rather than interstate) activity, the court reasoned that the consumption of homegrown wheat by individual farms would, in the aggregate, have a substantial economic effect on interstate commerce, and so was within Congress's reach.

The court reaffirmed this rationale in 2005 in Gonzales v. Raich, when it validated Congress's authority to regulate the home cultivation of marijuana for personal use. In doing so, however, the justices emphasized that—as in the wheat case—''the activities

regulated by the [Controlled Substances Act] are quintessentially economic.'' That simply would not be true with regard to an individual health insurance mandate.

The otherwise uninsured would be required to buy coverage, not because they were even tangentially engaged in the ''production, distribution or consumption of commodities,'' but for no other reason than that people without health insurance exist. The federal government does not have the power to regulate Americans simply because they are there. Significantly, in two key cases, United States v. Lopez (1995) and United States v. Morrison (2000), the Supreme Court specifically rejected the proposition that the commerce clause allowed Congress to regulate noneconomic activities merely because, through a chain of causal effects, they might have an economic impact. These decisions reflect judicial recognition that the commerce clause is not infinitely elastic and that, by enumerating its powers, the framers denied Congress the type of general police power that is freely exercised by the states.

This leaves mandate supporters with few palatable options. Congress could attempt to condition some federal benefit on the acquisition of insurance. States, for example, usually condition issuance of a car registration on proof of automobile insurance, or on a sizable payment into an uninsured motorist fund. Even this, however, cannot achieve universal health coverage. No federal program or entitlement applies to the entire population, and it is difficult to conceive of a ''benefit'' that some part of the population would not choose to eschew.

The other obvious alternative is to use Congress's power to tax and spend. In an effort, perhaps, to anchor this mandate in that power, the Senate version of the individual mandate envisions that failure to comply would be met with a penalty, to be collected by the IRS. This arrangement, however, is not constitutional either.

Like the commerce power, the power to tax gives the federal government vast authority over the public, and it is well settled that Congress can impose a tax for regulatory rather than purely revenue-raising purposes. Yet Congress cannot use its power to tax solely as a means of controlling conduct that it could not otherwise reach through the commerce clause or any other constitutional provision. In the 1922 case Bailey v. Drexel Furniture, the Supreme Court ruled that Congress could not impose a ''tax'' to penalize conduct (the utilization of child labor) it could not also regulate under the commerce clause. Although the court's interpretation of the commerce power's breadth has changed since that time, it has not repudiated the fundamental principle that Congress cannot use a tax to regulate conduct that is otherwise indisputably beyond its regulatory power.

Of course, these constitutional impediments can be avoided if Congress is willing to raise corporate and/or income taxes enough to fund fully a new national health system. Absent this politically dangerous—and therefore unlikely—scenario, advocates of universal health coverage must accept that Congress's power, like that of the other branches, has limits. These limits apply regardless of how important the issue may be, and neither Congress nor the president can take constitutional short cuts. The genius of our system is that, no matter how convinced our elected officials may be that certain measures are in the public interest, their goals can be accomplished only in accord with the powers and processes the Constitution mandates, processes that inevitably make them accountable to the American people.

EXECUTIVE SUMMARY: WHY THE PERSONAL MANDATE TO BUY HEALTH INSURANCE IS UNPRECEDENTED AND UNCONSTITUTIONAL

(By Randy Barnett, Nathaniel Stewart, and Todd F. Gaziano)

As the Congressional Budget Office explained: ''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 any good or service as a condition of lawful residence in the United States.'' Yet, all of the House and Senate health-care bills being debated require Americans to either obtain or purchase expensive health insurance, estimated to cost up to $15,000 per year for a typical family, or pay substantial tax penalties for not doing so.

The purpose of this compulsory contract, coupled with the arbitrary price ratios and controls, is to require some people to buy artificially high-priced policies as a way of subsidizing coverage for others and an industry saddled with the costs of other government regulations. Rather than appropriate funds for higher federal health-care spending, the sponsors of the current bills are attempting, through the personal mandate, to keep the forced wealth transfers entirely off budget.

This takes congressional power and control to a strikingly new level. An individual mandate to enter into a contract with or buy a particular product from a private party is literally unprecedented, not just in scope but in kind, and unconstitutional either as a matter of first principles or under any reasonable reading of judicial precedents.

THE COMMERCE CLAUSE

Advocates of the individual mandate have claimed that the Supreme Court's Commerce Clause jurisprudence leaves ''no doubt'' that the insurance requirement is a constitutional exercise of that power. They are wrong.

Although the Supreme Court has upheld some far-reaching regulations of economic activity, most notably in Wickard v. Filburn and Gonzales v. Raich, neither case supports the individual health insurance mandate. In these cases, the Court held that Congress's power to regulate the interstate commerce in a fungible good—for example, wheat or marijuana—as part of a comprehensive regulatory scheme included the power to regulate or prohibit the intrastate possession and production of this good. In both cases, Congress was allowed to reach intrastate economic activity as a means to the regulation of interstate commerce in goods.

Yet, the mandate to purchase health insurance is not proposed as a means to the regulation of interstate commerce; nor does it regulate or prohibit activity in either the health insurance or health care industry. Indeed, the health care mandate does not purport to regulate or prohibit activity of any kind, whether economic or noneconomic. By its own plain terms, the individual mandate provision regulates no action. To the contrary, it purports to ''regulate'' inactivity by converting the inactivity of not buying insurance into commercial activity. Proponents of the individual mandate are contending that, under its power to ''regulate commerce . . . among the several states,'' Congress may reach the doing of nothing at all!

In recent years, the Court invalidated two congressional statutes that attempted to regulate non-economic activities. In United States v. Lopez (1995), it struck down the Gun-Free School Zones Act, which attempted to reach the activity of possessing a gun within a thousand feet of a school. In United States v. Morrison (2000), it invalidated part of the Violence Against Women Act, which regulated gender-motivated violence. Because the Court found the regulated activity in each case to be noneconomic, it was outside the reach of Congress's Commerce power, regardless of its effect on interstate commerce.

To uphold the insurance purchase mandate, the Supreme Court would have to concede that the Commerce Clause has no limits, a proposition that it has never affirmed, that it rejected in Lopez and Morrison, and from which it did not retreat in Raich. Although Congress may possibly regulate the operations of health care or health insurance companies directly, given that they are economic activities with a substantial effect on interstate commerce, it may not regulate the individual's decision not to purchase a service or enter into a contract.

If Congress can mandate this, then it can mandate anything. Congress could require every American to buy a new Chevy Impala every year, or a pay a ''tax'' equivalent to its blue book value, because such purchases would stimulate commerce and help repay government loans. Congress could also require all Americans to buy a certain amount of wheat bread annually to subsidize farmers.

Even during wartime, when war production is vital to national survival, Congress has never claimed such a power, nor could it. No farmer was ever forced to grow food for the troops; no worker was forced to build tanks. And what Congress cannot do during wartime, with national survival at stake, it cannot do in peacetime simply to avoid the political cost of raising taxes to pay for desired government programs.

OTHER CONSTITUTIONAL PROBLEMS

Senators and Representatives should also know that:

There are four constitutionally relevant differences between a universal federal mandate to obtain health insurance and the state requirements that automobile drivers carry liability insurance for their injuries to others on public roads;

A review of the tax provisions in the House and Senate bills raises serious questions about the constitutionality of using the taxing power in this manner; and

Since there literally is no legal precedent for this decidedly unprecedented assertion of federal power, it is highly unlikely that the Supreme Court would break new constitutional ground to save an unpopular personal mandate.

Members of Congress have a responsibility, pursuant to their oath, to determine the constitutionality of legislation independently of how the Supreme Court has ruled or may rule in the future. But Senators and Representatives also should know that, despite what they have been told, the health insurance mandate is highly vulnerable to challenge because it is, in truth, unconstitutional. And all other considerations aside, the highest obligation of each Member of Congress is fidelity to the Constitution.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I rise to support the constitutional point of order raised against the legislation before us by the distinguished Senator from Nevada. I applaud the senior Senator from Nevada for taking this step so that all Senators can take a position on whether this legislation is constitutional, or whether this legislation is consistent with the Constitution each of us is sworn to protect and defend.

The Senator from Nevada serves with me on the Senate Finance Committee,

and he will remember that I started raising constitutional questions and objections against this legislation more than 3 months ago during the committee markup, and so has he.

This body has spent its time debating the policy of this legislation. This is a terrible piece of legislation that will raise insurance premiums, raise taxes, and limit access to care.

Mr. President, I ask unanimous consent that an editorial from yesterday's Wall Street Journal, titled ''Change Nobody Believes In,'' be printed in the RECORD following my remarks.

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

(See exhibit 1.)

Mr. HATCH. From the standpoint of policy, Mr. President, we should not pass this bill. Perhaps more importantly, from the standpoint of the Constitution, we may not pass it.

Much has changed since the founding of this great country, but one thing has not: The liberty we love requires limits on government. It requires limits on government. It always has and it always will. America's founders knew that and built limits into the system of government they established. Those limits come primarily from a written Constitution that delegates enumerated powers to the Federal Government. We must point to at least one—at least one—of those powers as the basis for any legislation we pass.

The Constitution and the limits it imposes do not mean whatever we want them to mean.

This legislation brings America into completely uncharted political and legal waters and I will not be at all surprised if there is litigation challenging it on constitutional and other grounds. In the Finance Committee, I offered an amendment to add a procedure for the courts to handle constitutional challenges in an expedited fashion. The Finance Committee chairman ruled that amendment out of order so that it could not even be considered. That was his decision, but that means that any future challenges will be handled the old fashioned way, even if that means an extended, rather than an expedited, process.

I ask unanimous consent that a memo prepared by the Conservative Action Project be printed in the RECORD following my remarks. Its signatories include former U.S. Attorney General Edwin Meese; former Congressman David McIntosh; Karen Kerrigan, President of the Small Business and Entrepreneurship Council; and Brian McManus of the Council for Affordable Health Insurance.

The PRESIDING OFFICER. Without objection it is so ordered.

(See Exhibit 2.)

Mr. HATCH. Let me briefly repeat the constitution objections I have been raising for the past few months and which the Senator from Nevada carefully raised this morning. First, the only enumerated power that conceivably can support the mandate for individuals to purchase health insurance is the power to regulate interstate commerce. Since the 1930s, the Supreme Court has expanded this to include regulation of activities that substantially affect interstate commerce. But the key word is activities. Congress has never crossed the line between regulating what people choose to do and ordering them to do it. The difference between regulating and requiring is liberty. I agree with the 75 percent of Americans who believe that the insurance mandate is unconstitutional because Congress's power to regulate interstate commerce does not include telling Americans what they must buy.

Second, the financial penalty enforcing the insurance mandate is just that, a penalty. It is not a tax and, therefore, it is constitutional only if the insurance mandate it enforces is constitutional. If it is a tax, it is a direct tax on individuals rather than an excise tax on transactions and, therefore, it violates article I, section 9, of the Constitution which requires that direct taxes be apportioned according to population.

Third, the excise tax on high-cost insurance plans, which applies differently in some states than in others, is unconstitutional because it is not uniform throughout the United States as required by article I, section 8. The Supreme Court has said that to be uniform as the Constitution requires, an excise tax must have the same force and effect wherever the subject of the tax is found. Not only is this not the case with this tax, which makes it plainly unconstitutional, but that is exactly the design and intention of those who drafted this legislation.

Fourth, the legislation orders states to establish health benefit exchanges which will require states to pass legislation and regulations. If they do not, or even if the Secretary of Health and Human Services believes they will not by a certain date, the Secretary will literally step into each state and establish and operate this exchange for them. This is a direct violation of the division between federal and state government power. The Supreme Court could not have been clearer on this point, ruling over and over that Congress may regulate individuals but may not regulate states. Congress has no authority to order states, in their capacity as states to pass legislation. We have encouraged states to pass legislation, we have bribed them, we have even extorted them by threatening to withhold federal funds. But this legislation simply commandeers states and makes them little more than subdivisions of the federal government. In 1997, the Supreme Court held ''state legislatures are not subject to Federal direction'' and reaffirmed ''categorically'' its earlier holding that ''the federal government may not compel the states to enact or administer a federal regulatory program.'' That should be clear enough for Senators to understand here in this body.

I was amazed to learn that when President Franklin D. Roosevelt chose Frances Perkins as his Secretary of Labor, they discussed social policy legislation including health insurance. As Secretary Perkins later described it, they agreed that such legislation would pose ''very severe constitutional problems,'' including fundamentally altering federal-state relationships. That is why the Social Security Act relies on the payroll tax. Even the Roosevelt administration, which oversaw the most dramatic expansion of Federal power in our Nation's history, would not go as far as the legislation before us today would go.

Should this legislation become law, there would be nothing that the federal government could not do. Congress would be remaking the Constitution in its image, rather than abiding by the Constitution's limits as liberty requires. There must come a time when we say that the political ends cannot justify the constitutional means, that the Constitution and the liberty it protects are more important than we wonderful Members of Congress are. That time is now, and that is why we will vote to sustain this constitutional point of order.

I wish to personally thank and congratulate the distinguished Senator from Nevada for his work on this issue, for his work on the committee, because he was one of the more energetic and more capable people on the committee in raising some of these very important issues such as this constitutional set of issues we have been discussing over this short period of time today. I am grateful for him, I am grateful he has raised it, and I am grateful to be able to be here on the floor to support him in his raising of this constitutional point of order when he chooses to do so.

I yield the floor.

EXHIBIT 1

[From the Wall Street Journal, Dec. 21, 2009]

CHANGE NOBODY BELIEVES IN

And tidings of comfort and joy from Harry Reid too. The Senate Majority Leader has decided that the last few days before Christmas are the opportune moment for a narrow majority of Democrats to stuff ObamaCare through the Senate to meet an arbitrary White House deadline. Barring some extraordinary reversal, it now seems as if they have the 60 votes they need to jump off this cliff, with one-seventh of the economy in tow.

Mr. Obama promised a new era of transparent good government, yet on Saturday morning Mr. Reid threw out the 2,100–page bill that the world's greatest deliberative body spent just 17 days debating and replaced it with a new ''manager's amendment'' that was stapled together in covert partisan negotiations. Democrats are barely even bothering to pretend to care what's in it, not that any Senator had the chance to digest it in the 38 hours before the first cloture vote at 1 a. m. this morning. After procedural motions that allow for no amendments, the final vote could come at 9 p.m. on December 24.

Even in World War I there was a Christmas truce.

The rushed, secretive way that a bill this destructive and unpopular is being forced on

the country shows that ''reform'' has devolved into the raw exercise of political power for the single purpose of permanently expanding the American entitlement state. An increasing roll of leaders in health care and business are looking on aghast at a bill that is so large and convoluted that no one can truly understand it, as Finance Chairman Max Baucus admitted on the floor last week. The only goal is to ram it into law while the political window is still open, and clean up the mess later.

Health costs. From the outset, the White House's core claim was that reform would reduce health costs for individuals and businesses, and they're sticking to that story. ''Anyone who says otherwise simply hasn't read the bills,'' Mr. Obama said over the weekend. This is so utterly disingenuous that we doubt the President really believes it.

The best and most rigorous cost analysis was recently released by the insurer WellPoint, which mined its actuarial data in various regional markets to model the Senate bill. WellPoint found that a healthy 25-year-old in Milwaukee buying coverage on the individual market will see his costs rise by 178%. A small business based in Richmond with eight employees in average health will see a 23% increase. Insurance costs for a 40-year-old family, with two kids living in Indianapolis will pay 106% more. And on and on.

These increases are solely the result of ObamaCare—above and far beyond the status quo—because its strict restrictions on underwriting and risk-pooling would distort insurance markets. All but a handful of states have rejected regulations like ''community rating'' because they encourage younger and healthier buyers to wait until they need expensive care, increasing costs for everyone. Benefits and pricing will now be determined by politics.

As for the White House's line about cutting costs by eliminating supposed ''waste,'' even Victor Fuchs, an eminent economist generally supportive of ObamaCare, warned last week that these political theories are overly simplistic. ''The oft-heard promise 'we will find out what works and what does not' scarcely does justice to the complexity of medical practice,'' the Stanford professor wrote.

Steep declines in choice and quality. This is all of a piece with the hubris of an Administration that thinks it can substitute government planning for market forces in determining where the $33 trillion the U.S. will spend on medicine over the next decade should go.

This centralized system means above all fewer choices; what works for the political class must work for everyone. With formerly private insurers converted into public utilities, for instance, they'll inevitably be banned from selling products like health savings accounts that encourage more cost-conscious decisions.

Unnoticed by the press corps, the Congressional Budget Office argued recently that the Senate bill would so ''substantially reduce flexibility in terms of the types, prices, and number of private sellers of health insurance'' that companies like WellPoint might need to ''be considered part of the federal budget.''

With so large a chunk of the economy and medical practice itself in Washington's hands, quality will decline. Ultimately, ''our capacity to innovate and develop new therapies would suffer most of all,'' as Harvard Medical School Dean Jeffrey Flier recently wrote in our pages. Take the $2 billion annual tax—rising to $3 billion in 2018—that will be leveled against medical device makers, among the most innovative U.S. industries. Democrats believe that more advanced health technologies like MRI machines and drug-coated stents are driving costs too high, though patients and their physicians might disagree.

''The Senate isn't hearing those of us who are closest to the patient and work in the system every day,'' Brent Eastman, the chairman of the American College of Surgeons, said in a statement for his organization and 18 other speciality societies opposing ObamaCare. For no other reason than ideological animus, doctor-owned hospitals will face harsh new limits on their growth and who they're allowed to treat. Physician Hospitals of America says that ObamaCare will ''destroy over 200 of America's best and safest hospitals.''

Blowing up the federal fisc. Even though Medicare's unfunded liabilities are already about 2.6 times larger than the entire U.S. economy in 2008, Democrats are crowing that ObamaCare will cost ''only'' $871 billion over the next decade while fantastically reducing the deficit by $132 billion, according to CBO.

Yet some 98% of the total cost comes after 2014—remind us why there must absolutely be a vote this week—and most of the taxes start in 2010. That includes the payroll tax increase for individuals earning more than $200,000 that rose to 0.9 from 0.5 percentage points in Mr. Reid's final machinations. Job creation, here we come.

Other deceptions include a new entitlement for long-term care that starts collecting premiums tomorrow but doesn't start paying benefits until late in the decade. But the worst is not accounting for a formula that automatically slashes Medicare payments to doctors by 21.5% next year and deeper after that. Everyone knows the payment cuts won't happen but they remain in the bill to make the cost look lower. The American Medical Association's priority was eliminating this ''sustainable growth rate'' but all they got in return for their year of ObamaCare cheerleading was a two-month patch snuck into the defense bill that passed over the weekend.

The truth is that no one really knows how much ObamaCare will cost because its assumptions on paper are so unrealistic. To hide the cost increases created by other parts of the bill and transfer them onto the federal balance sheet, the Senate sets up government-run ''exchanges'' that will subsidize insurance for those earning up to 400% of the poverty level, or $96,000 for a family of four in 2016. Supposedly they would only be offered to those whose employers don't provide insurance or work for small businesses.

As Eugene Steuerle of the left-leaning Urban Institute points out, this system would treat two workers with the same total compensation—whatever the mix of cash wages and benefits—very differently. Under the Senate bill, someone who earned $42,000 would get $5,749 from the current tax exclusion for employer-sponsored coverage but $12,750 in the exchange. A worker making $60,000 would get $8,310 in the exchanges but only $3,758 in the current system.

For this reason Mr. Steuerle concludes that the Senate bill is not just a new health system but also ''a new welfare and tax system'' that will warp the labor market. Given the incentives of these two-tier subsidies, employers with large numbers of lower-wage workers like Wal-Mart may well convert them into ''contractors'' or do more outsourcing. As more and more people flood into ''free'' health care, taxpayer costs will explode.

Political intimidation. The experts who have pointed out such complications have been ignored or dismissed as ''ideologues'' by the White House. Those parts of the health-care industry that couldn't be bribed outright, like Big Pharma, were coerced into acceding to this agenda. The White House was able to, er, persuade the likes of the AMA and the hospital lobbies because the Federal government will control 55% of total U.S. health spending under ObamaCare, according to the Administration's own Medicare actuaries.

Others got hush money, namely Nebraska's Ben Nelson. Even liberal Governors have been howling for months about ObamaCare's unfunded spending mandates: Other budget priorities like education will be crowded out when about 21% of the U.S. population is on Medicaid, the joint state-federal program intended for the poor. Nebraska Governor Dave Heineman calculates that ObamaCare will result in $2.5 billion in new costs for his state that ''will be passed on to citizens through direct or indirect taxes and fees,'' as he put it in a letter to his state's junior Senator.

So in addition to abortion restrictions, Mr. Nelson won the concession that Congress will pay for 100% of Nebraska Medicaid expansions into perpetuity. His capitulation ought to cost him his political career, but more to the point, what about the other states that don't have a Senator who's the 60th vote for ObamaCare?

''After a nearly century-long struggle we are on the cusp of making health-care reform a reality in the United States of America,'' Mr. Obama said on Saturday. He's forced to claim the mandate of ''history'' because he can't claim the mandate of voters. Some 51% of the public is now opposed, according to National Journal's composite of all health polling. The more people know about ObamaCare, the more unpopular it becomes.

The tragedy is that Mr. Obama inherited a consensus that the health-care status quo needs serious reform, and a popular President might have crafted a durable compromise that blended the best ideas from both parties. A more honest and more thoughtful approach might have even done some good. But as Mr. Obama suggested, the Democratic old guard sees this plan as the culmination of 20th-century liberalism.

So instead we have this vast expansion of federal control. Never in our memory has so unpopular a bill been on the verge of passing Congress, never has social and economic legislation of this magnitude been forced through on a purely partisan vote, and never has a party exhibited more sheer political willfulness that is reckless even for Washington or had more warning about the consequences of its actions.

These 60 Democrats are creating a future of epic increases in spending, taxes and command-and-control regulation, in which bureaucracy trumps innovation and transfer payments are more important than private investment and individual decisions. In short, the Obama Democrats have chosen change nobody believes in—outside of themselves—and when it passes America will be paying for it for decades to come.

EXHIBIT 2

CONSERVATIVE ACTION PROJECT

The Conservative Action Project, chaired by former Attorney General Edwin Meese, is designed to facilitate conservative leaders working together on behalf of common goals. Participation is extended to leaders of groups representing all major elements of the conservative movement—economic, social and national security.

Edwin Meese, former Attorney General; Steven G. Calabresi, Professor, Northwestern Law School; Mathew D. Staver, Founder & Chairman, Liberty Counsel; Curt Levey, Executive Director, Committee for Justice; Marion Edwyn Harrison, Past President, Free Congress Foundation; Kenneth Klukowski, Senior Legal Analyst, American

Civil Rights Union; Wendy Wright, President, Concerned Women for America; J. Kenneth Blackwell, Visiting Professor, Liberty School of Law; Grover Norquist, President, Americans for Tax Reform; William Wilson, President, Americans for Limited Government; Matt Kibbe, President, Freedom Works; Jim Martin, President, 60 Plus Association; David McIntosh, former Member of Congress, Indiana; Colin A. Hanna, President, Let Freedom Ring; Tony Perkins, President, Family Research Council; Brent Bozell, President, Media Research Center; Brian McManus, Council for Affordable Health Insurance; Karen Kerrigan, President, Small Business & Entrepreneurship Council; T. Kenneth Cribb, former Counselor to the U.S. Attorney General; Richard Viguerie, Chairman, ConservativeHQ.com; Alfred Regnery, Publisher, American Spectator.

MEMO FOR THE MOVEMENT

The Individual Mandate in ''Obamacare'' is Unconstitutional

Re: The mandate under the Obama-Pelosi-Reid healthcare legislation requiring American citizens to purchase health insurance violates the U.S. Constitution.

Action: We urge you to make this point to members of the U.S. Senate—and if a bill passes the Senate to impress upon members of both chambers of Congress—that the key provision in the healthcare legislation violates the U.S. Constitution.

Issue: Mandating that individuals must obtain health insurance, and imposing any penalty—civil or criminal—on any private citizen for not purchasing health insurance is not authorized by any provision of the U.S. Constitution. As such, it is unconstitutional, and should not survive a court challenge on that issue. Supporters of the legislation have incorrectly contended that the legal justification for the mandate is authorized by the Commerce Clause, the General Welfare Clause, or the Taxing and Spending Clause. Given that this mandate provision is essential to Obamacare; its unconstitutionality renders the entire program untenable.

The individual mandate is unconstitutional unless there is a specific constitutional provision that authorizes it. The federal government is a government of limited jurisdiction. It has only enumerated powers. Therefore unless a specific provision of the Constitution empowers a particular law, then that law is unconstitutional. There is no such authorization for the mandate.

The individual mandate is not authorized by the Commerce Clause. Most of those advocating the Democrats' bill say that Congress can pass this legislation pursuant to its power to regulate interstate commerce. That argument is incorrect, because there is no interstate commerce when private citizens do not purchase health insurance.

The Commerce Clause only covers matters where citizens engage in economic activity. The last time the Supreme Court struck down a law for violating the Commerce Clause, in United States v. Morrison (2000), the Court did so on the grounds that the activity in question was not an economic activity.

The Commerce Clause only extends to persons or organizations voluntarily engaging in commercial activity. Government can only regulate economic action; it cannot coerce action on the part of private citizens who do not wish to participate in commerce. In the most expansive case for Congress' power to regulate interstate commerce, Wickard v. Filburn (1942), the Court upheld the agricultural regulation in question against a wheat farmer who earned his entire living from growing and selling wheat, making him a willing participant in interstate commerce.

The Commerce Clause requires an actual economic effect, not merely a congressional finding of an economic effect. When the Court struck down the Violence Against Women Act in United States v. Morrison (2000), the Court noted that although the statute made numerous findings regarding the link between such violence and interstate commerce, it held that those findings did not actually establish an economic effect. Therefore the various interstate-commerce findings in the Senate version of the ''Obamacare'' legislation do not make the bill constitutional.

The individual mandate is not authorized under the General Welfare Clause. The Supreme Court made clear in United States v. Butler (1936) and Helvering v. Davis (1937) that the General Welfare Clause only applies to congressional spending. It applies to money going out from the government; it does not confer or concern any government power to take in money, such as would happen with the individual mandate. Therefore the mandate is outside the scope of the General Welfare Clause.

The individual mandate is not authorized under the Taxing and Spending Clause or Income Tax. The Constitution only allows certain types of taxation from the federal government.

The Article I Taxing and Spending Clause permits duties, imposts, excises and capitation taxes—duties, imposts and excises are taxes on purchases. A capitation tax is a tax that every person must pay, and the Constitution's apportionment rule requires that every person in each state must pay exactly the same amount. The Obamacare mandate is imposed on people who are making no purchase, and is a tax that some people in a state would pay, but others do not.

The Sixteenth Amendment allows an income tax. An income tax is imposed only on earnings, but people would have to pay this tax even if they had no income.

Therefore it cannot be any of these constitutionally-permitted taxes.

The individual mandate is unconstitutional regardless of whether there are criminal penalties involved. There is no distinction between criminal and civil penalties for determining the constitutionality of legislation, and the penalty imposed in Wickard v. Filburn (1942) was not a criminal penalty. Therefore even if the criminal sanctions were removed from the legislation, the imposition of any penalty or consequence for not purchasing insurance renders the mandate unconstitutional.

The individual mandate cannot be properly compared to requiring auto insurance. President Obama said in a Nov. 9 interview on ABC television that requiring people to buy health insurance and penalizing those that do not buy is acceptable because people are required to buy car insurance. That statement is untrue.

Only state governments can require people to get car insurance. While the federal government is limited to the powers enumerated in the Constitution, the states have a general police power. The police power enables state governments to pass laws for public safety and public health. The federal government has no general police power, and therefore could not require car insurance.

States do not require people to purchase car insurance. Driving a car is a privilege, not a right. States require people to get insurance only as a condition for those people who voluntarily choose to drive on the public roads. If a person chooses to use public transportation, or use a bicycle instead of a car, or operate a car only on their own property, they are not required to have car insurance, and cannot be penalized for lacking insurance.

FOR ADDITIONAL INFORMATION ON THE UNCONSTITUTIONALITY OF THE HEALTH CARE MANDATE, PLEASE VISIT THESE WEBSITES

http://www.washingtonpost.com/wpdyn/content/article/2009/08/21/AR2009082103033.html

http://www.politico.com/news/stories/1009/28463.html

http://www.politico.com/news/stories/1009/28620.html

http://www.politico.com/news/stories/1009/28787.html

http://www.foxnews.com/opinion/2009/10/30/ken-klukowski-open-letter-pelosi-gibbs-constitution-individual-mandate/

http://www.washingtontimes.com/news/2009/nov/02/beware-the-health-insurance-police/

http://www.heritage.org/Research/LegalIssues/1m0049.cfm

http://blogs.abcnews.com/politicalpunch/2009/11/interview-with-the-president-jail-time-for-those-without-health-care-insurance.html

http://hatch.senate.gov/public/index.cfm?FuseAction=PressReleases.Detail&PressRelease__id=097a758af3–1b78–be3e-e03a-c0eea6d515c.5

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I know we are waiting for the chairman of the Finance Committee to come. I ask unanimous consent to speak in the meantime, in these few seconds.

I thank the senior Senator from Utah. He is one of the best constitutional scholars we have here in the Senate. I appreciate his words and analysis on why this bill is unconstitutional. I think his words this morning were eloquent. I appreciate his support as I raise this constitutional point of order.

I yield to the Senator from Montana, the chairman of the Finance Committee.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have a unanimous consent request that I understand has been cleared by both sides.

I ask unanimous consent that after Senator ENSIGN raises the point of order that the Reid substitute amendment No. 2786 is in violation of the Constitution, the point of order be set aside to recur on Wednesday, December 23, at a time to be determined by the majority and Republican leaders.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I rise to make a constitutional point of order against this bill on the grounds that it violates Congress' enumerated powers in article I, section 8 and that it violates the fifth amendment of the Constitution. I ask for the yeas and nays.

The PRESIDING OFFICER. Pursuant to the unanimous consent, the point of order shall be set aside until a time tomorrow to be determined by the majority leader and the minority leader.

Is there a sufficient second? There appears to be a sufficient second. The yeas and nays are ordered on the point of order.

Mr. ENSIGN. 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. SESSIONS. 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. SESSIONS. Mr. President, I would like to share some thoughts on a central issue to this health care reform legislation. It is something that has gotten away from us. I do not believe we fully comprehended it. It is a critical issue.

It seems to me we are double-counting the money. We are counting money twice—maybe the largest amount of money ever having been counted twice in the history of the world. It is very dangerous with regard to the financial viability of the legislation we are looking at today.

It was promised by the President that this legislation would not add one dime to the national debt. He said yesterday that this legislation would strengthen Medicare. This is his quote:

. . . and Medicare will be stronger and its solvency extended by nearly a decade.

I don't think that is accurate. We have had other Members of the Democratic leadership say that.

What we know is we have, I think it is about $460 billion in tax increases and $490 billion in tax increases and a little less than that, $400-and-some-odd billion in savings to Medicare, and that accounts for the $871 billion the bill is supposed to cost in the first 10 years. Of course, that is not an accurate ultimate cost since most of the benefits in the bill do not start until the fifth year. So when you go the first full 10 years of the bill, it costs $2.5 trillion. But, regardless, let's take this first 10 years. The assertion is that Medicare can be improved and that we can take money from it and that this is going to make Medicare stronger and that somehow this is going to extend the solvency of Medicare, which is going insolvent by 2017. That is because more and more people are retiring and people are living longer, among other reasons. So the cost of Medicare goes up.

I guess what I am framing now is what I believe to be a matter of the greatest importance. The argument is that somehow, by cutting benefits in Medicare by almost $½ trillion, we are somehow strengthening Medicare. That would be true if the money that was taken out of Medicare Programs and benefits and providers who are providing the benefits—if that money were maintained in Medicare.

They go to the CMS, the institution that keeps up with Medicare costs, the Center for Medicare and Medicaid Services, the Chief Actuary there, Mr. Richard Foster, and they ask him: Won't these reductions in Medicare expenses extend the life of Medicare? And he said yes. OK. He said yes. He writes this:

We estimate that the aggregate net savings to the Part A trust fund under the PPACA—

That is the health care reform bill—

would postpone the exhaustion of the trust fund assets by 9 years—that is from 2017 under current law to 2026 under the proposed legislation.

Great. That is not a bad result. But then he goes on. I think he was simply asked: If you reduce spending in Medicare by effecting these cuts and reductions in Medicare, will it extend the life? And he said it would. However, I think he felt he might have been used, and so he didn't leave it right there. I think he believed there was something else afoot in this deal. He goes on to say this:

In practice, the improved Part A financing—

That is what he is talking about, these cuts—

. . . the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under the PPACA)—

The health care bill—

and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

Maybe I am wrong about this. I am happy to have a lot of people look at it. Wait a minute, we have the President of the United States yesterday saying that Medicare will be stronger and its solvency extended for nearly a decade. We have Senator DURBIN and I think Senator BAUCUS and others saying the same thing. We are talking about $400 billion.

So I would think this Congress can get a straight answer somewhere. Don't you? Well, I have been asking staff, and they say it is double counting.

I said: What do you mean it is double counting?

Well, Senator GREGG, the ranking Republican on the Budget Committee—former chairman of the Budget Committee—said it is double accounting. He offered an amendment, a simple amendment that said any money that is saved in Medicare stays in Medicare. Did that pass? No. They voted that down. That should be a signal, I submit. That should be a red flag.

So now I am looking at this really, really hard because the way I see the financial accounting of the bill, perhaps the largest bogus part of it is to say that the money that is being saved from Medicare is going to create this new program and, at the same time, saying the savings in Medicare are going to be used to extend the life of Medicare. You cannot do both.

That is what Mr. FOSTER said in his letter of December 10:

In practice, the improved Part A financing—

He is talking about the improved Part A financing of Medicare by these cuts—

the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under the PPACA) and to extend the trust fund. . . .

All right. You got it? Let's go back and leave out the parentheses:

. . . the improved Part A financing cannot be simultaneously used to finance other Federal outlays . . . and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

So they got CBO to score it as if the money is going into the new health care reform, and they got CMS to score it as if it is saving Medicare.

Now, I was a Federal prosecutor for a long time. I know the responsibilities placed on presidents of corporations. If the president of a corporation were to issue a prospectus and ask people to invest money in his company and support his program, his agenda, and he said: I have $400 billion or $400,000 I am going to spend in it, and he knew the money was being spent on something else and he did not really have that money, that is a criminal offense, and people would go to jail for it.

I am worried about it; I really am. This is unbelievable. So we are going to get to the bottom of this. If I am wrong, I would like to see where the money is coming from. So my question to my colleagues is—and apparently this has been asked by staff for weeks and they have never gotten a straight answer—where do you get this $871 billion? How much of that are you counting coming from savings in Medicare; and where, precisely, are you getting it from Medicare? If you are going to spend it on the new program, how are you going to say it is going to strengthen Medicare as to its insolvency problem?

You cannot count the money twice, and I believe that is what Mr. FOSTER was suggesting; that you cannot simultaneously count the money ''despite the appearance of this result from the respective accounting conventions.'' What he is saying is, CBO is following proper accounting conventions for their scoring and CMS is doing it their way and it gives the appearance that you have some money that can be spent twice. But he said you cannot simultaneously use the same money. Now, isn't that true? But in this body, I do not know.

What is another fundamental matter of budgetary importance that goes with it? The President has repeatedly said that not one dime will be added to the national debt, and it should not be. We cannot continue to do that. So when this legislation started, the idea was we needed to reform a lot of problems in our health care situation.

One of the problems everybody recognized was that the doctors are not getting paid in a proper fashion for the work they do. Under the Balanced Budget Act of 1997, we effected rules on how much doctors should be paid, and if those rules went into effect today, doctors would have a 21-percent pay cut on all Medicare work. Already Medicare physicians are leaving the practice because they get paid much

less from the Federal Medicare Program than they do from private health insurance. So they would rather do private work than Medicare. But they do Medicare—most doctors do—but if you took them another 21 percent down, they would not.

Every year, they come here and ask the Congress to waive this cut, and Congress—as part of the duplicity of this body that has gone on under both parties, but each year it gets worse and worse—we fix it, and we do not execute the cut. But we only do it for 1 year. So when we have a budget, it assumes a 10-year budget. As President Obama submitted it to us, it assumes in the first year you pay the physicians and you do not cut their pay. Then for 9 years you assume they get a 21-percent reduction. It is a gimmick because you cannot cut the physicians 21 percent; and we know that. If we budgeted for the full amount, we are going to have to pay physicians, and we are going to pay physicians, then there would be a big hole because we do not have the money and we either have to cut something else, raise taxes, or raise the debt. What we have been doing is paying for it with more debt.

Well, each year, the doctors get all upset because they are staring at a 21-percent pay cut. All their representatives in the AMA and everybody come up every year and tell us: Don't cut our pay, and we do not—1 year at a time.

This is a misrepresentation. It hides the financial precariousness of our position. It is not good. It should never continue. It needs to be permanently fixed, and that was supposed to be part of health care reform from the beginning. The President said that is what he was going to do. The leadership on the other side said that is what they were going to do.

But what happened—when they met in their secret rooms, and they all wheeled and dealed and tried to add up these numbers and see how they could manipulate numbers and scores and accounting to make it add up so they could say it would not add one penny to the debt—they could not get around the $250 billion it takes to pay the doctors. They could not do it.

They say, under this bill, there is a $130 billion surplus over the first 10 years. But it does not fix the doctor payments for Medicare in health care work, Medicaid. It does not fix it. So when you fix it, it costs $250 billion. There is no dispute about that. We have analyzed that. The accounting numbers are clear: $250 billion.

So what the Democrats tried to do—it was a clever—Senator ENSIGN referred to it the other day as a shell game. They moved the doctor fix out of the health care reform—just took it out—and so, therefore, you do not have the $250 billion hole and you just put it over here. They thought they would be clever, they would just pass it, and we would add it all to the debt. They tried to do so, so they could tell the doctors they tried to vote to have a permanent fix of their payments. ''Doctors, we are going to take care of it. We'll just pass it, and every penny of this will add to the debt.''

Well, 13 Democrats would not swallow that, and I think every Republican opposed it, and it went down. So now I think we have a 2-month fix. Two months is where we are working from today, so we would not have a slashing of payments to physicians by failure to fix it.

So they just took it out, and I assume we are going to have some other gimmick to hide that $250 billion. So if you put the $250 billion cost into health care reform, you end up with a $120 billion deficit right off the bat. Then, when you get into this double accounting of $450 billion, you have really got a mess. They are estimating $871 billion in income for the first 10 years of this plan. As I analyze it, you have a $250 billion hole from not paying the doctors, and then you have a $400-plus billion double accounting—the savings from Medicare.

So it is just not good. I am telling you, we only have one President. He has a lot of things on his mind, and it is very frustrating. But I will say one more thing he said at that press conference. He said, and he has repeatedly stated: It is going to reduce health care premiums for your insurance. Right? This was yesterday, after this bill passed. He says he is tired of people carping about the cost of the bill. Remember him saying that—tired of these carpers? I guess he is talking about me because I have been carping about the cost of it for some time because the numbers do not add up.

All right. They claim the legislation will reduce insurance costs. This is the score of the CBO about small businesses. What about insurance premiums? If you are small businesses, the average premiums today for a family is $13,300. If the Reid bill passes, by 2016 the premiums will be $19,200. Is that cutting premiums? Well, yes, it is because under the Reid bill it would increase, on average, 5.38 percent. But if we did not pass any bill at all, it would increase it 5.46 percent. So it saved money; it reduced your premium. It will be $19,200 instead of $19,300. That is for small businesses.

What about for large businesses? Does it cut insurance premiums there? For large business plans, under the Reid bill, the increase, if we pass this legislation, would be 5.41 percent per year in your premiums. If you do not pass the bill at all, it would be 5.56 percent. Is that a savings? Very little. Instead of $21,100, under the Reid bill you would pay $20,300.

Then, finally, the individual market—this is the people who already are the ones who are getting hurt because they are not in group plans; they don't have employers paying a third, a half, or whatever, for insurance; they don't get the same tax breaks. They are getting killed. Barbers, individual people who can't get into group plans, it is horrible for them. What happens to the individual market? Under the Reid bill, their premiums would go up 7.77 percent per year. They would go up more than the others. What about if we didn't do anything? How much would their bills go up then, their insurance bills? Only 5.51 percent. Theirs go up more than 2 percent.

So I am just saying this legislation may have a great vision, it may have a great idea about trying to make the system work better, but it doesn't. These are huge costs. It is not financially sound. It is not going to reduce our premiums. It is going to increase the percentage of wealth in America going to health care instead of reducing it as I thought we were supposed to do from the beginning.

I see my colleague, Senator KYL, here. I would just leave it at that. I thank my colleagues. But if I am correct about these numbers, we shouldn't vote for the bill. People should change their vote. If I am in error, I would like to be informed of how I am in error.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Arizona.

Mr. KYL. Mr. President, I listened carefully to what my colleague said, and as a member of the Finance Committee, I can tell him that he is not in error. What he said about premiums going up under this legislation is true. The promise was that premiums would not go up. Well, they continue to go up. In fact, in the case of the individual market, the legislation itself causes them to go up between 10 and 13 percent. My colleague is not in error.

If the Reid bill has a motto, it is ''in government we trust.'' With the turn of every page, it is no exaggeration to say the Reid bill creates a Washington takeover of health care, to wit, $2.5 trillion in new government spending; $494 billion in new taxes; $465 billion in Medicare cuts; 70 new government programs; and higher health insurance premiums for individuals, families, and businesses. It is packed with new Federal requirements and mandates that amount to a stunning assault on liberty. Even in the absence of a government-run insurance plan, this bill would give the government virtually total control over health care. The bill itself is the government option.

Michael Cannon, a health policy expert at the Cato Institute, warns that the bill's linchpin, the requirement that all individuals buy a government-approved insurance plan, would be ''the most sweeping and dangerous measure in any of the bills before Congress.''

Of course, if Congress mandates that every American purchase health insurance, then Congress gets to define exactly what that health insurance entails. Welcome to the future, where bureaucrats and politicians know what is best for families, small businesses, and seniors. For example, under this legislation the government would set new Federal rating rules. Rating rules dictate how insurers may calculate premiums, which experts estimate would

increase premiums by a whopping 72 percent in my home State of Arizona. They would determine the coverage benefits for all plans regardless of consumer preferences or health care needs. The government would limit insurers to offering only four plans. You have to offer two; you can't offer any more than four. They would prohibit individuals over the age of 30 from enrolling in a catastrophic health care plan. And to highlight the magnitude of government interference and micromanagement, the bill even dictates the number of pages—by the way, it is no more than 4—and the font size—no smaller than 12 point—of the summary of benefits. These are just a few examples of the heavyhanded government controls. Indeed, the word ''shall'' appears 3,607 times in the Reid bill. I haven't had a chance yet to count how many more times it appears in the almost 400-page amendment that has been now filed.

In my view, however, the most dangerous consequence of the Washington takeover of health care is the inevitable rationing that will result in the delay and denial of care. Ensuring access to the highest quality care and protecting the sacred doctor-patient relationship should be the fundamental goals of any health reform effort. These intangibles are the cornerstones of U.S. health care, the very things Americans value most, that the Reid bill puts in jeopardy. Don't look for the words ''ration'' or ''withhold coverage'' or ''delay access to care'' in the bill. Obviously, they are not there. Instead, contemplate the inevitable result of new Federal rules that aim to reduce health care costs but will inevitably result in delayed or denied tests, treatments, and procedures deemed to be too expensive. For example, the Reid bill would establish a Medicare Commission. This is an unelected body of bureaucrats with the task of finding, and I am quoting here, ''sources of excess cost growth,'' meaning, of course, tests and treatments that are allegedly too expensive or whose coverage would mean too much government spending on seniors. The Commission's decisions will result in the delay and denial of care.

Medicare already delays more medical claims than private insurers do, but this bill would redistribute Medicare payments to physicians based on how much they spend treating seniors. It would rely on recommendations from the U.S. Preventive Services Task Force—the entity, by the way, that recently recommended against mammograms for women under the age of 50—to set preventive health care benefits, and it would authorize the Federal Government to use comparative effectiveness research when making coverage determinations. It is this last issue—comparative effectiveness research—that I wish to discuss in more detail.

The Reid bill would create a new entity called the Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research. This research, which is already done in the private sector, compares the effectiveness of two or more health care services or treatments, and, of course, it is used to provide doctors with information as to what works best in most cases. The goal is to provide patients and doctors with better information regarding the risks and benefits of a drug, let's say, for example, versus surgery in a particular kind of case. The question before us is not as to the merits of the research but, rather, whether the research should be used by the government to determine the treatments and services covered by insurance.

In a recent interview, President Obama said:

> What I think the government could do effectively is to be an honest broker in assessing and evaluating treatment options.

The President believes the government should assess and evaluate health care treatments, and certainly that is how health care works in other countries such as Great Britain. For example, there, they have the National Institute for Health and Clinical Excellence; the acronym is NIHCE. NIHCE routinely uses comparative effectiveness research to make cost-benefit calculations. They don't even attempt to hide it. On its Web site, NIHCE says:

> With the rapid advancement in modern medicine, most people accept that no publicly funded health care system, including the National Health Service, can possibly pay for every new medical treatment which becomes available. The enormous costs involved mean that choices have to be made.

Choices are made, and this is the key: They are made by the government, not by patients and doctors.

The National Health Service, which runs Britain's health care system, has issued guidance known as the Liverpool Care Pathway whereby a doctor can withdraw fluids and drugs from a patient if the medical team diagnoses that the patient is close to death. Many are then put on continuous sedation so that they die free of pain. Doctors warn that some patients are being wrongly put on the pathway, which is creating a self-fulfilling prophecy that they would die because sedation often masks the signs of improvement.

Also, due to excessively long waiting periods, the National Health Service launched what they call an End Waiting, Change Lives campaign. The goal here was to reduce patients' waiting times to 18 weeks from referral to treatment—18 weeks. That is supposed to be a good thing? That is 4½ months for an appointment. This is why many Europeans and Canadians visit the United States each year, places such as the Mayo Clinic in Arizona, for access to the treatments that are denied to them in their own countries.

These are the dangers of a government-run health care system. The government, not the patients and doctors, makes the health care decisions. The government decides if your health care is an effective use of government resources, and the government inevitably interferes in your ability to access care. That is rationing, and it is wrong. This is not what Americans want or expected from health care reform. Yet it is precisely the path Congress is taking. Perhaps that is why 61 percent of Americans disapprove of this bill.

Nothing in the Reid bill would prohibit the Federal Government from using comparative effectiveness research, just as it has done in Britain, as a tool to delay or deny coverage of a health care treatment or service. The bill actually empowers the Secretary of Health and Human Services to use comparative effectiveness research when making coverage determinations. For example, on page 1,684 of the original bill, it says:

> The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage . . .

And so on.

As the Washington Examiner notes:

> Health and Human Services Secretary Kathleen Sebelius would be awarded unprecedented new powers under the proposal, including the authority to decide what medical care should be covered by insurers as well as the terms and conditions of coverage and who should receive it. The Reid legislation lists 1,697 times where the Secretary is given the authority to create, determine, or define things in the bill.

I know my colleagues will point to language that says: Well, the Secretary can't make these decisions on rationing care solely on the basis of comparative effectiveness research. Whoopee. I am not sure if that is a word we can use on the Senate floor, but big deal. You can't make it solely on that basis, but you can use comparative effectiveness research to ration care. That is wrong, and that is what this bill permits. And despite numerous times to get a simple amendment I offered to say no comparative effectiveness research can be used by a Federal agency to deny care or treatment—simple—the other side says: No, we already have it covered. It is good enough. Our language is fine. You don't need that simple statement that would prevent this research from being used in that fashion. I think it is pretty clear that the attempt here is to be able to do it.

During the Finance Committee, I asked the majority counsel why they didn't bar the Federal Government from using comparative effectiveness research as a tool to ration care. The staff replied:

> The reason why we did not include an express prohibition is we did not want to limit the institute from considering areas of science that have a budgetary impact, if you will.

That is, of course, precisely the problem. Americans do not want the Federal Government using this research as a cost-cutting tool.

Regina Herzlinger, a professor at Harvard Business School, warns: CER could easily morph into an instrument of health care rationing by the Federal Government without the appropriate safeguards.

That is why earlier this year I joined Senator MCCONNELL and Senator ROBERTS and Senator CRAPO in introducing the PATIENTS Act, and it creates this firewall to prevent the use of research for rationing. We filed it as an amendment, but, of course, we are not going to be able to vote on it now that cloture has been invoked. This is the third time this year we have tried to institute this pro-patient firewall, but obviously we are not going to be able to vote on it, as I said.

From the very beginning of the health care reform debate, I have believed that any bill should be rooted in a simple yet fundamental principle: that very American should be able to choose the doctor, hospital, and health plan of his or her choice. No Washington bureaucrat should interfere with that right or substitute the government's judgment for that of a physician. There is nothing more important to Americans, other than maybe their freedom, than the health of their family—and that does, by the way, include an element of freedom, obviously, the freedom to do what you think is best for your family. We would all do anything we could to help a loved one. We don't want Washington impeding our ability to do so.

Maybe that is why this new Washington Post-ABC poll ''finds the public generally fearful that a revamped system would bring higher costs while worsening the quality of their care.'' Even, they say, those without insurance are evenly divided on the question of whether their care would be better if the system were overhauled.

The American people get it. The bill itself is the government option, but in government, they do not trust.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Ms. LANDRIEU. Mr. President, I come to the floor today in support of the Patient Protection and Affordability Act, and I wish to give some of the reasons why I am supporting this important piece of legislation.

Before my colleague leaves the floor, I would like to respond to his last comment. One of the reasons the American people are having difficulty believing the government can do anything right is that he and his colleagues have spent the last several decades convincing them that the government is the problem and that the government can't do anything right.

Even in the face of strong evidence that suggests otherwise, they continue that worn-out, tired mantra. People in my State and around the Nation are getting tired of it because they know that government must stand sometimes to protect them from abusive practices in the private marketplace, abusive practices of insurance companies, to try to level the playing field and set the rules. Of course, those on the other side don't believe in a level playing field and rules. They believe citizens in our country should be at the whim and mercy of the private market. That has been their philosophy for decades. That is not the philosophy of the Democratic Party. We believe in a public-private partnership. We believe in a level playing field. We believe in giving people the opportunity to earn their way, with fair rules in place. That party has never believed that, and that is at great issue in the underlying debate. They can continue to fabricate myths and lies about this bill, but those of us who support it will proudly continue to tell the truth about it.

I have served in public office for 30 years as a State legislator, State treasurer, and now as a United States Senator. But it doesn't take 30 years to know the health care system our citizens live under and live with today is expensive, wasteful, and painfully inefficient.

From my visits with doctors and nurses, to seniors on Medicare, to recent college graduates struggling to afford coverage, to dozens and dozens of small business owners who are frightened to death that they are not going to be able to continue in their business because of the rising cost of health care, it has become clear to me that the time for reform is now.

In Louisiana, the average family spends more than $12,000 each year for health insurance. That is almost 100 percent of the earnings of a person who is working 40 hours a week at the minimum wage. Think about that. Only in one developed country in the world would we have a system that says if you go to work 40 or 50 hours a week, you have the privilege of taking all that money and having to purchase health care in the system that my colleagues on the other side want to advocate for. That is wrong. We must drive down the cost to the government, to businesses, and to families. This bill will begin to do that.

Since 2000, the amount that working families are charged for health insurance has increased by 91 percent. That doesn't seem to concern my colleagues on the other side of the aisle. If this Congress stood by and did nothing, those costs would nearly double in the next 6 years, with economists predicting that families in my State will pay a whopping $23,000 for insurance in 2016—an 85-percent increase. To say that a different way, that means that if we do nothing, the average family in Louisiana will be paying 60 percent of their income for health care—if they can find it and if they can get around a preexisting condition—leaving only 40 percent of their wages to cover food, education, children, housing, transportation, and everything else families need their funds for.

These skyrocketing costs are burdening families not just in Louisiana but in every State. We don't have a choice but to change. We cannot continue to rely just on the private market without reform, without guidelines, and without incentives to change. Our people will be priced out of the market. Maybe that is what my colleagues on the other side of the aisle want. That is not what I want.

Small businesses are struggling to remain competitive and to turn a profit. In the face of highly unstable and unpredictable health care costs this is getting harder and harder. As chair of the Small Business Committee, I have held 23 hearings and roundtables just this year, and several of them have been focused on how the current health care system and volatile health care costs are hurting our Nation's small businesses.

Today, small businesses are seeing their health care costs increase faster than the prices of the products and services they sell four times faster than the rate of inflation since 2001. Premiums for single policies increased by 74 percent for small businesses in the last eight years, according to a 2009 Kaiser Family Foundation survey. Nationally, 40 percent of small businesses say that health care costs have had a negative impact on other parts of their business.

What are we supposed to do, stand here and do nothing? No—that is why acting now is so important. That is why this bill is so important, because the status quo is unsustainable. It is unsustainable for our government and it is unsustainable for small businesses.

Even though families, businesses, and government budgets are being squeezed by unsustainable costs, Senate Republicans are doing everything they can to argue for the status quo. Why? I don't know. Each day, they find a new excuse for their obstruction. I wish they had put the same amount of passion, energy, and creative thinking into contributing policies and ideas to this debate as they have into their delaying tactics. Every amendment they offered was to send the bill backward, not forward. They seem hell-bent on defeating and not improving this bill, contrary to their statements on the floor.

The Republicans have charged that we are rushing in to vote for this bill. That is simply not true. We have been debating this issue on and off for the last 87 years.

Republican President, Theodore Roosevelt, made national health insurance a plank in his party platform when he sought the Presidency in 1912. President Harry Truman, in 1945 and then again in 1948, called on Congress to pass reform legislation to expand quality health care coverage to more Americans. President Truman believed we needed a stronger system and that the federal government must play a role in establishing a more robust system of care. His critics called his approach ''socialized medicine.'' Sound familiar?

Only in Washington would 87 years be considered rushing!

This has been a debate that has gone on with particular intensity for the last 2 years, as our Presidential candidates took to the airwaves in debate after debate—Republican and Democratic—outlining their ideas for reform. This hasn't sprung up in the last

2 weeks. This hasn't sprung up in the last 2 months.

Millions of Americans went to the polls, understanding, in large measure, what we needed to do to change the system. Despite the rhetoric from the other side, that is the reality, and the record will reflect that. Instead of coming to the table and working with Democrats to write a bipartisan bill, Republicans chose to put partisan party politics first. I listened to my friend, MAX BAUCUS, this morning. I, myself, who thought I had followed carefully the work of the Senate Finance Committee, was actually moved to hear the number of meetings—dozens and dozens, maybe hundreds and hundreds of meetings—he attempted to have in a bipartisan way months ago, years ago, with Republicans. Then, at some point, they decided they thought that politics was more important than policy. I think they made the wrong choice.

They fabricated death panels, distorted Medicare cuts, and undermined and disrespected the role of government in protecting its citizens. They have engaged in a relentless misinformation campaign, aimed solely at using fear to sway public opinion against this bill.

Recently—just yesterday—Senator JOHN MCCAIN, our colleague from Arizona, claimed that the American people are opposed to reform, and he speaks about the will of the majority. I remind my colleague from Arizona that the will of the majority spoke loud and clear last year when they elected President Obama to be President and decided not to elect him. The President is carrying out the will of the majority of the people by trying to provide for them hope and opportunity in an area that has eluded us for 87 years.

This is a good effort, a strong effort, and I most certainly believe that the will of the American people is being heard. The other side has tried to paint a picture of a nation opposed to health care reform. Recent polls show otherwise. When we cut through the misinformation and scare tactics, when Americans hear what is in the bill, they overwhelmingly support it.

According to a recent CNN poll, 73 percent of Americans support expanding Medicaid for the poor. Americans know what most of us know: Most people on Medicaid are the working poor. These are people who wake up early in the morning, work hard all day, and they go back home at night, often by taking public transportation because they don't have an automobile. They work hard. They are American citizens. But they don't have enough money to spend 60 percent or 80 percent of their income on health insurance in a broken, unbridled, unfixed private market. So we join together with our States to provide them access to care through the Medicaid system. I support that. And in this bill, the Federal Government will pick up a large share of the cost of expanding coverage.

That same poll showed that providing subsidies for families that make up to $88,000 a year is favored by 67 percent of Americans. Additional regulations on insurance companies, such as banning denial of coverage for those with preexisting conditions are favored by 60 percent of the American people.

I am one of the Democrats who didn't want to eliminate insurance companies. I believe in private markets. But there have to be certain rules and regulations in order for the private market to work for everyone, and not just for those with wealth or those with the inside scoop on how private markets work.

So we are incentivizing a healthier insurance industry—not coddling it but encouraging it to be competitive and to provide services and coverage for more people in our country.

A recent poll by the Mellman Group shows that support for this bill exists in all States. In my home State of Louisiana, when the provisions of the bill were actually read to voters, 57 percent of Louisianians supported the bill, with 43 percent strongly supporting the reform effort. And most importantly, 62 percent of Louisianians oppose using the filibuster to stop health care reform.

I will read the language used in the poll because people say you can say anything in polls, which is true. If pollsters are not reputable, they can twist and distort. I will read the language used by the poll to describe the plan:

> The plan would require every American citizen to have health insurance and require large employers to provide coverage to their employees. It would require insurance companies to cover those with pre-existing conditions and prevent them from dropping coverage for people who get sick, while providing incentives for affordable preventive care. Individuals and small businesses that do not have coverage would be able to select a private insurance plan from a range of options sold on a National Insurance Exchange. Lower and middle income people would receive subsidies to help them afford this insurance, while those individuals who like the coverage they already have will be able to keep their current plan.

This is a very accurate description of this bill before us—the Patient Protection and Affordable Care Act. It is not a government takeover. There is no public option. There is a national plan available now to every American, just like the Members of Congress and the Federal employees have. There will be exchanges—similar to shopping centers—and Americans will be go to the exchanges and choose from a number of insurance options. The prices will be more transparent. Administrative costs will be lowered. You will not need a Ph.D. to be able to read these policies—they will be written in plain English.

Again, this is not a government takeover, as the other side claims. That is why 57 percent of people in Louisiana, when given the right information, without the rhetoric, without the railing, without the distortions, say: Absolutely, I am for a public-private partnership.

The American people elected President Obama to bring about change. A big part of the change President Obama and Democrats promised during the campaign was improving health care for all Americans. Thanks to the President's leadership and the leadership of Senator REID and many others, we are taking several meaningful steps toward fulfilling that promise.

With the exception of two colleagues, Republicans have failed to negotiate in good faith. I want to say how much I respect our two colleagues from Maine, Senator SNOWE and Senator COLLINS. I have been in dozens of meetings with both of them and know that they struggled mightily to find a way to work with us and to support this bill. I have not spoken with them in the last few days, so I will not discuss their reasons for withholding their support. I am sure they will express those on the floor. But I can say that they are the exception to the rule. I know Senator GRASSLEY, Senator GRAHAM, Senator BENNETT, and a few others engaged early on. I want to acknowledge them and I appreciate their good will. But, unfortunately, the leadership of the Republican Party chose politics over policy. I am disappointed that not a single Republican could support an end to the filibuster. I suppose it is easy to stay unified when the only word in your vocabulary is NO. Although Democrats did not initially agree on exactly how to get there, we were united in saying yes to the common goal of delivering meaningful health care reform to America's families and small businesses. It has been difficult. Some of us come from very conservative States. Some of us come from liberal States. We have diverse populations in our States that have different needs and different views. It has not been pretty, but it has been a practical and hopefully a positive exercise that will bring comfort, support, and strength to the American people and to our economy.

I do hold out hope that when we take our vote on final passage, Republicans will recognize this historic opportunity and vote in favor of this bill that will reduce costs and increase access to health care for millions of Americans.

Last month, I stood here on the floor of the Senate to announce my intention to vote in favor of bringing Senator REID's melded bill to the floor. At the time, I was very clear that my vote was not an indication that I supported that particular version of the bill. My vote was to bring that bill to the floor so that we could do the legislative work the American people sent us here to do.

After weeks of floor debate and amendments and round-the-clock negotiations, that work has been completed. We produced a health care bill that is significantly improved from the one that came to the floor. I would like to share a few thoughts about why, in my view, it is improved.

Through tough negotiations, Senate Democrats have developed a consensus that blends the best of public and private approaches to reduce costs, expand coverage, and increase choice and competition for Americans and have done so without a government-run public option.

Since I continue to hear distortions from my colleagues on the other side, let me be clear: there is no government-run public option in this bill. Instead, we reached an agreement to provide private health insurance plans to be sold nationwide. The Office of Personnel Management will negotiate lower premiums, just as they negotiate the plans currently available to Federal employees and to Members of Congress. Importantly, we ensured that at least one nonprofit plan will be offered in every State exchange and that the States cannot opt out at the whim of every Governor and legislature. For the first time in our Nation's history, Americans will have an opportunity to have the same kind of insurance that federal employees, including Members of Congress, have.

In addition, there has been a lot of talk about the cost of this bill to the government and to taxpayers. There have been a number of false claims about how this bill will add to the deficit and be a burden to our children and grandchildren. The fact is, this bill is completely paid for and it will reduce the deficit by $132 billion over the next 10 years and as much as $1.3 trillion in the following 10 years.

Based on our efforts, the Congressional Budget Office and the Nation's premier economists have confirmed that premiums will go down over time or remain stable so that wages for millions of Americans can increase. When this bill is passed, 31 million uninsured Americans will have access to quality health coverage.

This bill is a big step toward fiscal responsibility and a stronger economy. It aims to achieve these goals by streamlining the health insurance market, ensuring efficiency, and limiting insurance company administrative costs, and to some degree, their profits.

It also imposes an excise tax on insurance companies with high-cost plans. This will encourage employers to be more value-conscious purchasers of health insurance. Employers are expected to choose cheaper plans, and as less capital is spent on health care, wages will go up for hard-working families. Economists predict that this could give American workers a $223 billion pay raise, amounting to $660 per household.

I strongly urge that this provision be included in the final legislation. I know that there is fierce opposition to this on the House side. But—and the President has said this publicly and privately to us—this is one of the most significant provisions that will help drive down costs for the entire health care system. It cannot be jettisoned at this point in the debate. This provision must be in the bill for me to give my final support.

We have also created administrative savings through insurance exchanges, and during Senate consideration of the bill we strengthened the Independent Medicare Advisory Board to find more ways to reduce cost growth and improve quality.

The final Senate bill includes a substantial investment in community health centers and will provide funding to expand access to health care in rural communities and under-served urban areas as well. In Louisiana, federally-supported health clinics have saved the state over $354 million in emergency room visits by the uninsured. The legislation also expands access by increasing funding for rural health care providers and training programs for physician and other health care providers.

There are many parts of the current bill that I am proud to have fought for. The bill creates health insurance exchanges that will provide individuals, families, and small businesses with a wide variety of affordable choices and ensure that they will always have coverage, whether they change jobs, lose a job, move or get sick. These state-based exchanges will enable consumers to comparison shop online for health insurance which will drive down costs by increasing choice and competition.

The exchange will help the uninsured obtain needed coverage and will also help the more than 200,000 Louisiana residents who currently do not have insurance through their employer to get quality coverage at an affordable price. Many of these Louisianians in the exchange will qualify for a tax credit to help them purchase the insurance of their choice.

For example, in Calcasieu Parish, the median household income is $39,713. In the exchange created by this bill, the average family in Calcasieu would receive an affordability credit that limits what they spend on their premium to around 5.6% of their income or $2,225. Considering, right now the average Louisiana family is spending up to 28% of their income on health care, this is a huge improvement.

This version of the bill that we improved on the Senate floor now includes additional much-needed help for small business owners, led by Senator LINCOLN, Senator STABENOW, myself, and other members of my committee. Senator SHAHEEN, Senator CARDIN, Senator HAGAN, Senator BAYH, and others worked very diligently on these provisions.

While small businesses make up 74 percent of Louisiana's businesses, only 37 percent of them offered health coverage benefits in 2008. Of those, 62 percent say they are struggling to do so. Of the 64 percent who don't provide insurance, 87 percent say they can't afford it.

I worked closely with Senator STABENOW to improve affordability and choices for small businesses and amended the bill to make the bridge credit available immediately to help small businesses afford health insurance for their employees, and improve the tax credits for small businesses. This means that small businesses who want to offer quality health insurance to their employees will get tax breaks right away, rather than waiting until 2011. I also worked with Senator LINCOLN to expand the number of small businesses that will be eligible for tax credits so that more small businesses get help in offering health insurance coverage for their employees—allowing more small business workers to benefit. In all, these changes bring an additional $13 billion in tax relief—on top of the $27 billion already in the bill—to small businesses.

If you own a small business of 25 or less employees here is how reform will help you: Businesses with 25 or less employees whose average annual wages are less than $50,000 will get immediate help through a three-year bridge credit. The creation of exchanges and a 2 year exchange tax credit will lift the burden of excessive paperwork administrative costs. The exchanges will create more stable, secure choices for your employees

In Louisiana, more than 50,000 small businesses could be helped by this small business tax credit proposal!

This will help small business owners such as Mary Noel Black and her husband, who own a UPS franchise store in Baton Rouge. They offer their four employees group coverage and are willing to pay half the cost, but the premium rates have gone up so much that neither the workers nor the business can afford to pay the $3,600 a year per employee for insurance. To help Mary pay for the health insurance of each employee, beginning in 2011, Mary could get a $1,260 bridge credit per employee under this bill for 3 years. Then, in 2014, if she purchases coverage through the exchange, her business is eligible for an exchange credit of $1,800 per employee for an even more generous tax credit for another 2 years. This savings could mean the difference between offering insurance or dropping coverage because instead of costing her business $14,400 a year now for her four employees—a cost that is just unaffordable—the tax credit could initially bring her cost down to $9,360 and later to $7,200.

Through our work on the Senate floor during this public debate, we have made this good bill better for small business. Not only have we extended and expanded the small business tax credits, the legislation includes several amendments I authored to ensure small businesses continue to have a seat at the table once this bill is implemented.

The bill requires that small businesses receive information regarding reinsurance for early retirees, small business tax credits, and other issues specifically for small businesses regarding affordable health care options.

It lists Small Business Administration resource partners as eligible recipients of exchange public awareness

grants and will include all Small Business Administration partners in the program, including Women's Business Centers, SCORE, Minority Business Centers, Veteran Business Centers, and others.

The bill now requires the Government Accountability Office to specifically review the impact of exchanges on access to affordable health care for small businesses to ensure that exchanges are indeed making a difference for small business owners.

It also clearly states that agencies cannot waive the Federal acquisition regulation, which requires them to report small business contracting numbers and meet small business contracting goals of 23 percent.

There is a provision that modifies the definition of a full-time employee to take into account fluctuation in employee hours, and reduce the impact of employer responsibility requirements for industries with high turnover and that rely on part-time employees.

The bill eliminates penalties for businesses that wait up to 60 days to provide health insurance to their full-time employees.

Finally, the Patient Protection and Affordable Care Act establishes a national workforce commission to gather information on the health care workforce and better coordinate and implement workforce planning and analysis. The managers' amendment ensures that small businesses and the self-employed will be represented on the commission.

These are important considerations for small businesses and I was proud to ensure these concerns were addressed through the amendment process.

Despite claims from opponents of the bill, we have taken important steps to strengthen Medicare, not weaken it. The Senate health care reform bill creates an independent Medicare advisory board to find ways to reduce cost growth and improve quality and moves to a system that rewards quality over quantity. It reduces payments for preventable hospital readmissions in Medicare, and cuts waste, fraud and abuse by enhancing oversight, identifying areas prone to fraud and requiring Medicare and Medicaid providers and suppliers to establish compliance programs.

As much as our Republican colleagues have tried to scare seniors into opposing this bill, the fact is that Louisiana's 650,000 Medicare beneficiaries stand to gain from this health care reform bill. The AARP and many seniors' organizations are continuing to support this bill because they know it improves care for our seniors.

The bill lowers premiums by reducing Medicare's overpayments to private plans. All Medicare beneficiaries pay the price of excessive overpayments through higher premiums—even the 78 percent of seniors in Louisiana who are not enrolled in a Medicare Advantage plan. Without reform a typical couple in traditional Medicare would pay nearly $90 in additional Medicare premiums next year to subsidize these private plans.

Our bill extends the life of the Medicare Trust Fund by 9 years and lays the groundwork for a more sustainable health system. Thanks to these reform efforts, there will be no additional cost for preventive services under the Medicare program. This includes a free wellness visit and personalized prevention plan designed to help give beneficiaries the resources they need to take better care of themselves in these important years.

This legislation puts taxpayers' dollars above insurance company profits by forcing insurers to bid competitively for the business of Medicare beneficiaries and makes changes to the Medicare Advantage payment structure that will give insurers an incentive to deliver more value.

Another critical aspect of the bill is that it increases the amount of coverage Medicare Part D beneficiaries receive before they begin to pay out of pocket for their prescriptions. Right now, roughly 116,000 Medicare beneficiaries in Louisiana hit a wall in Medicare Part D drug coverage that will cost some of them an average of $4,080 per year. This reform legislation will provide a 50 percent discount for brand-name drugs.

Some of the bill's most important provisions will benefit the most important population—children.

The underlying bill includes a provision allowing children to remain on their parents' plans up until the age of 26. I have children. I would like to think that by 22 or 23, they will be on their own, they will be gainfully employed and off my payroll. But any of us who have raised children know that sometimes it takes a little more time to launch our children. I see Senator SHAHEEN, who is nodding. She has done this herself. It takes a little time to launch them. According to the latest data from the Census Bureau, in 2007 there were an estimated 13.2 million uninsured young adults. So the bill includes this important provision to allow kids to stay on their parents' insurance for a bit longer as they transition into adulthood.

But my question was, where do the young people who age out of the foster care system sign up, because they do not have parents? I was proud to work on a provision that Leader REID included in this bill to ensure that every young person who ages out of the foster care system will be able to stay on Medicaid until the age of 26 starting in 2014. Almost 30,000 young people age out of the foster care system every year, having never been adopted or reunified with their birth parents. The fact that they aged out is our failure as government. We have failed them once and we just can't fail them twice. We must support their transition to adulthood, and guaranteeing access to quality health care will help with that transition.

When this legislation is signed into law, insurance companies will not be able to drop children for preexisting conditions beginning immediately. This is crucial for families with children who have battled cancer or diabetes. When a parent loses a job, they may struggle to get insurance when they find new employment. Once this bill becomes law, no insurance company will be able to deny a child with preexisting conditions.

This health care reform bill holds insurance companies' feet to the fire to ensure they are accountable to their customers. By 2014, insurers will not be able to deny coverage due to preexisting conditions. That means they will not be allowed to drop you from coverage if you get sick or are in an accident.

Because of the good work of my colleagues Senator ROCKEFELLER and Senator BEN NELSON, this bill requires insurance companies to disclose the pricing of their benefits to ensure that premiums are spent on health benefits not profits and gives consumers rebates, putting the insurance companies' excessive profits back into your pockets. It contains new requirements ensuring that insurers and health care providers report on their performance, empowering patients to make the best possible decisions. Under this bill, a health insurer's participation in the exchanges will depend on its performance. Insurers that jack up their premiums before the exchanges begin will be excluded—a powerful incentive to keep premiums affordable.

Finally, I was also proud to work with Leader REID and Finance Committee Chairman MAX BAUCUS to address an inequity in the formula that determines the federal match of Medicaid dollars. As we all know, in 2005 Hurricanes Katrina and Rita ravaged the Gulf Coast and destroyed homes, neighborhoods, and even full communities throughout South Louisiana. In an effort to aid the recovery, Congress approved a much-needed aid package for Louisianians that infused grant dollars and direct assistance to speed our recovery.

Some of the necessary one-time recovery dollars were calculated into our state's per capita income. In addition, labor and wage costs increased because there was heightened recovery activity and a constriction in the market. Consequently, Louisiana's per capita income was abnormally inflated and put us in a category with richer states.

The result is that our federal match for Medicaid is scheduled to drop pretty dramatically. I worked with my colleagues to correct this formula. I never asked for special treatment for Louisiana, but only for understanding of our state's unique situation. We only wanted to be treated fairly and not to get penalized because we have been forced to rebuild following the worst natural disaster in the United States' history. Our federal Medicaid match rates should reflect that the reality on

the ground in Louisiana, not the cold calculations of inflexible federal formulas.

An important note is that this Medicaid funding fix was supported by every Member of our Congressional Delegation, and specifically and repeatedly requested by our Republican Governor Bobby Jindal. Some politicians in my state may run and hide when the heat gets turned up, but that's not the way I was raised. I never have and never will run from what I think is right. I was sent here to fight for my state and that is exactly what I'm doing.

Those who have dubbed this provision the ''Louisiana Purchase'' know little about lawmaking and even less about my views on health care reform. This Medicaid fix alone would not have been enough to earn my vote on this legislation. This was one of literally a dozen priorities I had as the Senate considered health care reform. I am voting for this bill because it achieves the goals I laid out at the beginning of this debate: it drives down costs and expands affordable health care choices for millions of families and small businesses in Louisiana and around the nation. Any claim to the contrary, is a pathetic lie meant to derail this bill, a tactic that was all too common during this debate.

Today, we stand on the verge of history, with an opportunity to support a bill that will provide health insurance to 31 million more Americans, reducing the deficit by $132 billion over the next ten years.

The bill is not perfect. It is not the exact health care bill that I would have written. I think the same could be said for each of my colleagues. It was a long, difficult process and during the course of completing this landmark bill there were a lot of twists and turns. But, as former President Clinton was fond of saying, we should never let the perfect become the enemy of the good.

And through hard work and good faith and tough negotiations and keeping our eye on the ball, Senate Democrats have actually crafted, in my view, an extraordinary piece of legislation that will go a long way to providing comfort and security to the American people who elected us to do so.

It will provide comfort and security for the local grocery store owner in Jennings, the 22-year-old in Lake Charles who has just left the foster care system, the single mother of three in Monroe, the 9-year-old boy in Natchitoches who was just diagnosed with diabetes, and the 70-year-old Medicare beneficiary in Houma who worked for three decades in the offshore oil industry.

The Patient Protection and Affordable Care Act will make a difference in these lives and millions more across America, and I urge my colleagues to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, I ask unanimous consent that the remaining Democratic time be divided equally between myself, Senator STABENOW, and Senator BINGAMAN.

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

Mrs. SHAHEEN. Mr. President, I wish to begin by congratulating Senator LANDRIEU and thanking her for all the hard work she has done on this bill—first of all for small business. I think we have significantly, with her leadership, improved this legislation for small business so that many of the small businesses in this country—many in my home State of New Hampshire—will now be able to get help as they try to cover their employees for health care. I also wish to congratulate her for all her good work to help children in the foster system. It is significant they will be able to get health insurance once they age out of the foster system and, of course, to help those, as she has pointed out, who have children who are in their early twenties and who are still trying to get settled in a profession.

My daughter was fortunate enough to have health insurance last year in her first job out of college. But now she is going to a new job that doesn't have health insurance, and so she will be able to be covered once this legislation is passed under our plan. As Senator LANDRIEU points out, it is going to make a real difference for families and for small business.

I am very pleased to be here today to support this legislation and also to try to dispel some of the myths we have heard from our colleagues on the other side of the aisle about what is actually in this legislation. Despite what many of our colleagues may want us to believe, passing this bill is the fiscally responsible thing to do. Our current health care system is a threat to the security of our families, our small businesses, and the entire economy of this Nation. The costs of health care in America make up almost 18 percent of our economy—our gross domestic product. That is more than any other industrialized country. Health care costs are rising three times faster than wages. The leading cause of about two-thirds of the bankruptcies in America is medical bills. Our current health care system is simply not sustainable.

The Patient Protection and Affordable Care Act moves us in a new direction—a direction that is fiscally responsible because this bill is fully paid for. In fact, according to the Congressional Budget Office, the Patient Protection and Affordable Care Act would reduce our Federal deficit by $132 billion over the next 10 years. In fact, this legislation represents one of the largest deficit-reduction measures we have seen certainly in many years and possibly ever.

Small businesses in my home State of New Hampshire and across this country are going to benefit from this legislation. We heard Senator LANDRIEU talk about many of the provisions she worked on—and many of which I cosponsored—to help improve the legislation for small business. The fact is, the steep annual increases in the cost of health insurance have been forcing more and more businesses to make the very difficult decision to either drop coverage for their workers or to increase their employees' contribution to the point that too many workers have had to decline coverage.

I have heard from a number of businesspeople in New Hampshire, and I wish to read what a couple of them have said.

A young woman named Adria Bagshaw testified this summer at a Small Business Committee field hearing we held in New Hampshire. Adria and her husband Aaron own the W.H. Bagshaw Company. It is a fifth-generation small manufacturing company in Nashua, NH. There aren't a lot of those fifth-generation companies left that are owned by the same family. They offer health insurance to their 18 employees and cover anywhere between 10 to 25 percent of their monthly premium. But now the premiums are $1,100 per month per family, and Adria is afraid she will have to cut back on the quality of their health insurance plan or the amount the company covers to make ends meet. The sad thing is that she says right now they are spending more on health insurance than they are for raw materials to make their products.

I also heard from a man named John Colony, who is a small business owner in the small, very picturesque town of Harrisville, NH. He e-mailed me saying:

> The cost of health insurance is the biggest problem that our small business faces.

He has 24 employees. He went on to say:

> The present system is expensive, inefficient and broken. I can't tell you how the 20 to 35 percent annual rate increases depress us all and there is no end in sight. Over the past five years, most of our employees have had to drop coverage because they simply can't afford to pay their share of the premium. I really believe that the time has come to put the existing system out of its misery.

Well, I am happy to tell John we are about to do that, because under this legislation, beginning next year, we provide significant tax credits for small businesses to help them pay for the cost of coverage for their workers. This bill contains a number of significant measures to rein in runaway health care costs—measures such as creating a new pathway for biologic drugs so we can get biologic generic drugs to the market and help lower costs for people. There are measures in this bill that will eliminate waste, fraud, and abuse—something that takes too big a chunk out of our health care dollar. There are also measures in here that will get rid of the subsidies

the government pays to insurance companies for Medicare Advantage plans. These are all commonsense actions that will save the government and health care consumers money over time.

In addition, this bill makes significant improvements to our health care delivery system. That is the way we provide health care for people. It injects more competition into the health care marketplace. Controlling health care spending is critical to address the fiscal health of this Nation—no pun intended. This legislation takes a very important first step in slowing down the growth.

I am sure every Member of the Senate—Republican and Democratic alike—has heard heartbreaking stories from our constituents about health care—stories about being denied health insurance, about having to stay at a job they do not like because of the fear of losing coverage, about frustration over the lack of choice and who provides their health insurance or a lack of understanding about their plan's limits until it is too late and they are facing financial peril. Well, this bill will, I am happy to say, change that. Not only do we ensure coverage for an additional 31 million people——

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

Mrs. SHAHEEN.—but we eliminate the abuses of the insurance companies.

I will be back to talk about some of these other areas.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first, I wish to thank my friend from New Hampshire for her advocacy on health care reform in general, but specifically working together on the areas that affect small business, I very much appreciate, and we are so pleased to have her in the Senate.

I come to the floor to join my colleagues. I know the chair of the Small Business Committee, Senator LANDRIEU, has been here and others will be here—Senator LINCOLN, who has played such a critical role in putting together the small business provisions in the bill.

I am very pleased to have authored one of the provisions in the managers' amendment that will guarantee that small businesses get immediate help starting next year—tax cuts to help them pay for the cost of health insurance. Michigan has close to 200,000 small employers that represent about 96 percent of the employers in our State.

Most folks who think of Michigan think of large employers, large manufacturers. But, in fact, the majority of our employers, as in the majority of each of our States, are small businesses. That is where the majority of the new jobs are being created. We have just 41 percent of our firms that have fewer than 50 employees who actually are able to offer health insurance. So less than half our small businesses are able to offer health insurance, which is why we are focused on small businesses in this reform bill.

The majority of people in this country who don't have insurance are actually working. The majority of us—about 60 percent—have insurance through our employers. We have about another 20 percent or so who receive their insurance through Medicare or Medicaid or the Veterans' Administration or some other public entity and then 15 to 20 percent of the people overall in America who don't have insurance are predominantly small businesses—people working for small businesses or they are self-employed or they are working one, two, or three part-time jobs just to try to hold things together. So that is a major focus of the health care reforms that are in the legislation that is before us.

I am very pleased we have been able to put together a package that has $40 billion in direct tax cuts—$40 billion in direct tax cuts—for small businesses across America to help them afford health insurance going forward, rather than waiting for the new insurance pooling—the exchange—which will provide additional help for small businesses. This help, this tax cut, starts right away. We will see 3.6 million small businesses that could qualify for the tax cuts in this bill that will begin next year.

In my State, that means over 109,000 small businesses that could be helped by the small business tax cuts that will make premiums more affordable. So I am very pleased to be part of a group of Members who came together and worked very hard to focus on the fastest growing part of the economy, which are our small businesses.

I will just share one story, and this was from Crain's Detroit, a highly respected business publication in Michigan. Mark Hodesh, who is the owner of an Ann Arbor home and garden store, said he has seen his health insurance premiums go up more than 300 percent since 1997. In 1996, he paid $132 in health care premiums a month per employee; and this year, regular premium increases have led him to pay upward of $375 per month for each employee. So that is a 300-percent increase. He says:

> I have been in small business for 40 years, and my conclusion is that without health care reform, these increasing costs will put me out of business.

That is the reality for businesses across this country. I do believe health care reform is directly tied to jobs, whether it is large businesses competing internationally that make a determination to move their facility because of health care costs, whether it is small businesses going out of business or having to decide if they keep people working or pay for health insurance or whether it is the self-employed person out on their own, in their own enterprise—maybe it is local realtor. We know realtors have struggled for years because they haven't been able to buy through a large insurance pool. That is what this reform is all about. That is what this legislation is all about, to help small businesses, people who are working out of their homes, who are self-employed, as well as people who have lost their job and then lost their insurance. That is what this is all about.

When we look at this legislation, according to the Small Business Majority, without health insurance reform that is in this legislation the annual costs of health benefits will more than double in less than a decade. They will more than double. We know, because we have seen the statistics, that when we talk about doubling health care costs for businesses in the next 10 years, it is estimated to equal another 3.5 million jobs.

We cannot afford to lose another 3.5 million jobs because of the doubling of health care costs in America. We are focused on creating more jobs. We need to be laser focused—certainly, I am, coming from Michigan—on creating jobs not losing jobs. According to the economic analysis of the Small Business Majority, health insurance reform could save up to 72 percent of small business jobs otherwise lost to a continuing rise in health care costs. We need those jobs.

Again, health insurance reform is all about saving lives, saving money, saving Medicare, and it is certainly about saving jobs. That is why I am so pleased we have made small businesses a major priority in this legislation—both through $40 billion in tax cuts for small businesses, creating the new insurance pool through which small businesses can get the same kind of deal, have the same kind of clout as a large business today in being able to negotiate with private companies, and other provisions that are in the bill as well.

There are many reasons to support health insurance reform. Standing up for small businesses is certainly at the top of the list.

I yield the floor.

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

Mr. BINGAMAN. Madam President, over the past few weeks we have heard a lot of heated debate about this health care proposal. Much of it has concentrated on a few key issues: whether there should be a public option, whether there should not be. Of course, much of that debate was on the Democratic side among Members with strongly held views on both sides of the issue.

The question of whether we should try to allow people 55 and older to buy into Medicare was also debated. There were strongly held views on that issue.

It is clear now we have a bill before us that will do neither one of those things but which I think will accomplish very major health care reform for the country. I want to just concentrate

for a few minutes on some of the other policies that are contained in this legislation that have received much less attention but which clearly are very constructive proposals that will dramatically improve the health care delivery system in the country.

I can remember when we started these discussions early in the spring and summer and had many meetings and hearings and workshops both in the HELP Committee and in the Finance Committee, there were statements made that—on the Democratic and Republican side—we can agree upon maybe 80, maybe 85 percent of the changes we ought to embrace in health care reform. The question is, What about the other 15 to 20 percent? I think we need to spend more time focused on that 80 to 85 percent, and let me do that for just a minute.

This Patient Protection and Affordable Care Act which Senator REID and others have introduced and is in the House legislation as well, both pieces of legislation do contain very important policies. Let me talk a minute about some of those.

First, this act before us includes long overdue reforms to increase the efficiency and the quality of the U.S. health care system while holding down the growth in costs. For example, the legislation includes payment reforms—I have championed those for a long time; others in this body have championed them as well—to shift from a fee-for-service payments system to a bundled payments system. This will reshape our health care reimbursement system to reward better care and not simply more care as the system currently does.

The legislation also includes broad expansion of quality reporting and pay-for-performance reforms that will further incentivize quality and efficiency. The legislation also puts in place the framework for a national quality strategy and several new key Federal oversight bodies to allow both providers and consumers to have unbiased information about whether health care treatments and devices and pharmaceuticals are effective and efficient.

We have heard a lot of charges made that trying to find out what is effective and efficient is objectionable somehow because it might lead to rationing of care. There is no rationing of care contemplated in this legislation. But how anyone could come to the Senate floor and argue against providing good, scientifically based information both to providers and the consumers about which treatments, which devices, which pharmaceuticals are effective and useful is hard for me to understand.

Second, this Patient Protection and Affordable Care Act includes a broad new framework to ensure that all Americans have access to quality and affordable health insurance. It includes the creation of new health insurance exchanges which will provide Americans a centralized source of meaningful private insurance, as well as refundable tax credits to ensure that the coverage they need is affordable. These new health insurance exchanges will help improve the choices that are available to Americans by allowing families and businesses to easily compare insurance plans and prices and the performance of those plans. This will put families rather than insurance companies or insurance bureaucrats or government bureaucrats in charge of health care. These exchanges will help people to decide which quality, affordable insurance option is right for them.

On the issue of cost, the nonpartisan Congressional Budget Office forecasts that this legislation would not add to the Federal deficit. In fact, the latest estimate they have given us is that it would reduce the deficit by $132 billion by 2019 and well over $1 trillion in the second 10-year period; that is, the period from 2020 to 2029.

On the subject of premium costs, which all of us care about, all Americans care about, CBO has also found that in the individual market the amount that subsidized enrollees would pay for coverage would be roughly 56 percent to 59 percent lower, on average, than the premiums they are expected to be charged when this law takes effect in the individual market under current law.

Among enrollees in the individual market who would not receive new subsidies, average premiums would increase by less than 10 to 13 percent—this, again, according to the Congressional Budget Office. The legislation would have smaller effects on premiums for employment-based coverage. Its greatest impact would be on smaller employers qualifying for new health insurance tax credits. For these businesses and their employees, the Congressional Budget Office predicts that premiums would decrease by somewhere between 8 and 11 percent, compared with the costs that they would have to pay under current law.

These estimates by the Congressional Budget Office are consistent with the estimates of the impact in my home State of New Mexico, where average families may see a decrease in premiums of as much as 60 percent from what they might otherwise have to pay. This is families, I am talking about, who would be eligible for these advance refundable tax credits.

In addition, about two-thirds of the people in my State of New Mexico would potentially be able to qualify for subsidies or for Medicaid. In fact, a quarter of our population in New Mexico is at an income level that would allow them to qualify for near full subsidies if they bought insurance through an insurance exchange or for Medicaid itself.

An overall decrease in premium costs also is consistent with the experience that the State of Massachusetts had after they enacted similar reform to what is now being considered in the Senate. There has been a substantial reduction in the cost of nongroup insurance in that State. In fact, the average individual premium in Massachusetts fell from $8,537 at the end of 2006 to $5,142 in mid-2009. That is a 40-percent reduction in premium for that coverage. This was at a time when the rest of the Nation was seeing a 14-percent increase.

Finally, much of the debate on health care reform has focused on insurance coverage. It is important to recognize that as we expand coverage to include more Americans, the demand for health care services is going to increase as well. A strong health care workforce is, therefore, essential for successful health reform. Within this country, approximately 25 percent of the counties are designated as health professional shortage areas. That is a measure that indicates that there are insufficient medical staff to properly serve that geographic area.

This problem is even more apparent in rural States such as mine, such as New Mexico. For example, 32 out of the 33 counties in our State—we have just 33 counties—32 of those counties have this shortage designation—health professional shortage area designation. As a result, New Mexico ranks dead last compared to all other States with regard to both access to health care and the ability to utilize preventive medicine.

This Patient Protection and Affordable Care Act also contains key provisions to improve access and delivery of health services throughout the Nation. These provisions include increasing the supply of physicians and nurses and other health care providers, enhancing workforce education and training, providing support for the existing workforce—health care workforce, increasing the support for community health centers.

I applaud Senator REID and Senator BAUCUS and Senator DODD and Senator HARKIN and many other colleagues in the Senate who worked so hard on this bill. The legislation represents major health care reform. It is time for the Senate to enact this critical and long overdue legislation. There will be chances and opportunities to improve on this legislation in the future. I hope to participate in some of those.

Nothing that is passed into law in this Congress or any Congress that I have served in is what it should be in all respects. But this legislation is extremely important and significant health care legislation. It will do a tremendous amount of good for a vast number of Americans and it will do that ''good'' in a very responsible way.

I urge my colleagues to support passage of this legislation so we can get on with a conference with the House of Representatives and finally settle on a bill that could be sent to President Obama for his signature.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Madam President, I know our leader is coming to speak,

but prior to him coming, I will take a portion of my time that has been allotted to me by my side.

I sat here with great interest listening to the Senator from New Mexico. He referenced the State of Massachusetts. I entered into the RECORD yesterday the 21 percent of the people under the plan who could not get care in Massachusetts because they could not afford the copay and the deductible. This is basically a copy or model off of that.

He also discussed the fact that this shows a $132 billion savings over the next 10 years. That is provided you do not think you are going to allow any increase in doctor payments and you are not going to reverse the 21-percent cut.

Madam President, my leader is here, and I will be happy to yield to him at this time.

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. MCCONNELL. Madam President, I thank my friend from Oklahoma. I will be very brief.

Madam President, Americans woke up yesterday stunned to read that Democrats had voted to end debate on the latest version of this massive bill while they were sleeping. They will be stunned again when they learn about this second early-morning vote to advance a bill that most of them oppose. Americans are right to be stunned because this bill is a mess. And so was the process that was used to get it over the finish line.

Americans are outraged by the last-minute, closed-door, sweetheart deals that were made to gain the slimmest margin for passage of a bill that is all about their health care. Once the Sun came up, Americans could see all the deals that were tucked inside this grab bag, and they do not like what they are finding. After all, common sense dictates that anytime Congress rushes, Congress stumbles. It is whether Senator so-and-so got a sweet enough deal to sign off on it. Well, Senator so-and-so might have gotten his deal, but the American people have not signed off.

Public opinion is clear. What have we become as a body if we are not even listening to the people we serve? What have we become if we are more concerned about a political victory or some hollow call to history than we are about actually solving the problems the American people sent us here to address? This bill was supposed to make health care less expensive. It does not. Incredibly, it makes it more expensive.

Few people could have imagined that this is how this debate would end—with a couple of cheap deals hidden in the folds of this 2,700-page bill and rushed early-morning votes. But that is where we are. Americans are asking themselves: How did this happen? How did a great national debate that was supposed to lead to a major bipartisan reform lead to a bag full of cheap legislative tricks inside a $2.3 trillion, 2,733-page bill that actually makes health care costs go up?

This legislation will reshape our Nation in ways its supporters will come to regret. But they cannot say they were not warned. The verdict of the American people has been clear for months: They do not want it.

Madam President, I thank my friend from Oklahoma, and I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Madam President, I would just follow with one comment to my leader as far as his comments.

In 2007, we passed a bill called the Honest Leadership and Open Government Act of 2007. That act requires the posting of any earmarks or direct benefits for Senators in any bill. It has to be posted. We have not seen that with this bill, though we know there are numerous and sundry specific earmarks for Members.

So my hope is that sometime during this process, we will take up the violation of this very law by the leader of this Chamber in terms of ignoring it and flaunting it. What he said, when we passed it, was it was a needed change, and now we see it ignored as they bring this bill to the floor.

Mr. MCCONNELL. I thank my friend from Oklahoma.

One thing about rushing, not only is there a potential violation of the provision the Senator from Oklahoma mentioned, but we are learning more about this bill every day as we scrub it and try to understand it and figure out what all is in it. All of that, of course, is made more possible by rushing things through in sort of an expedited, hurried fashion to get it by the American people before Christmas in the hopes they will not notice.

Mr. COBURN. I thank the leader.

I want to spend my time this morning kind of talking about how you control health care costs in our country. My experience, just from my qualifications—I have 9 years of experience in manufacturing medical devices. I did that as a young man, had hundreds of employees and a fairly large business. I left that business to become a physician. The call of my life was to help people directly rather than indirectly through my medical device association.

So I want to lay out the two different ways, the two different arguments for how we control health care costs because everybody in this Chamber wants to control health care costs. All the Democrats and all the Republicans do. We have 11 studies that say premiums are going to rise and one that says they are not under this bill. So that is not going to control costs.

But I want to read a story that a lady from my district wrote me because I think it is very important in us considering which way we go.

Dr. COBURN,

I hope you don't mind a personal story, but as I listen to the health care debate, I can't help but think constantly of my middle daughter. I am convinced that Chloe would have lost her chance for a normal life, had these policies—

In this new health care bill—

been in effect two years ago. No government agency could possibly have understood Chloe's unique needs or her extremely rare condition.

After a perfectly healthy childhood, my seventeen-year-old showed me that her left arm was twitching and wouldn't stop. Within weeks, the entire left side of her body was jerking constantly, every waking moment of every day. Her MRI revealed more than one periventricular heterotrophic nodule—

That is a growth around the ventricular system, the fluid system of the brain—

but her first two neurologists weren't sure there was a connection between the [changes in her movement and the movement disorder and the symptoms and the nodules]. They certainly had nothing useful to offer in terms of treatment. But I made the rash promise to my daughter that someone, somewhere, knew what to do, and that we would not stop looking until we found that person. Unlike mothers in a government run system, I was free to research the options and apply where I wanted. Our search took less than three months.

Chloe's pediatric movement disorder specialist at Mayo Clinic called her condition ''unique'' and unclassifiable. He had to debate her case with his neurology team, but in the end they were willing to try an unprecedented series of brain surgeries. Chloe was desperate to live a normal life again, so my husband and I agreed, though perhaps you can imagine what an excruciating decision that was. Today, Chloe twitches a little, but anyone who didn't know her history would think she is just fidgeting. She is an honors linguistics student at OU, and she even takes dance lessons. She recently started driving again. She said once, ''Mom, without the surgery, I would be strapped into a wheelchair now.

I know that Chloe would never have had the unique care she needed, if we had been required to petition a government agency for permission. A less dedicated person than her subspecialist would have tried to classify her condition and restrict her to known treatments. In fact, other subspecialists wanted to make those same restrictions. Chloe's doctor learned how to treat her by spending a great deal of time with her, by talking to her and to us for hours at a time, and by observing her in multiple contexts. I fear for the next mother whose child has an unclassifiable condition, and whose treatment is planned by a faraway committee with a diagnostic manual open on the table. Chloe won't be in that manual.

The thing that keeps people from getting health care in America today is the cost of health care. We have had all sorts of attempts of, how do we do that? We have had the Massachusetts model, and, as entered into the RECORD yesterday, they have insurance reform. Almost everybody in Massachusetts is covered. Yet last year 21 percent of those people who were covered could not get care because they could not afford the deductibles and copays. So expanding insurance and expanding the model does not solve it.

So you can either approach controlling costs or you can ration care. What has happened in this bill, as it comes through, is we have chosen to ration care. My colleagues are going to dispute that, but I want to offer significant evidence to offset that and discuss what is in the bill and to also discuss what is not in the bill.

What is not in the bill is a prohibition against rationing, which all of my colleagues on both the Finance Committee and the HELP Committee voted against, which means you are for rationing if you vote against, a prohibition. The leader denied an amendment on the floor of the Senate to eliminate rationing, so we do not get to see where everybody stands. But we understand the intent. So there is no question that the way we are going to control costs is to limit your access by rationing health care.

The other side of controlling costs is to incentivize the prevention of disease and incentivize payments for good outcomes when we manage chronic disease that is there in an efficient and effective way. That is not in the bill. That is not anywhere in the bill. What we have to do is incentivize an insurance company to invest in the management of chronic disease rather than to pay for the consequences of the chronic disease. That is not in the bill either.

So we get two choices.

Now, what do we find in this bill? We find a Medicare advisory commission. They actually dropped the name ''Medicare'' from it, but we find an advisory commission that is going to tell us how much money we have to cut from Medicare, and we either have to cut that amount or make some cuts somewhere else.

We have the U.S. Preventive Services Task Force, and we have already seen during the debate on this bill when they do something that is based on cost alone—not clinical; breast cancer screening for women between the ages 40 to 50—when they do something on the basis of cost instead of clinical, we run in and jump and say no, but we are going to pass a bill that is going to totally empower that. Seventeen times in this bill is the U.S. Preventive Services Task Force referenced in what it is going to tell us what to do, and it is not going to tell us just in Medicare and Medicaid, it is going to tell us in every area what we are going to do. But because there was such a reaction to the first recommendation based on cost—and let me explain what that was. They said that if you are age 50 and over, the incidence of finding somebody with breast cancer is 1 in 1,470 people, but if you are between the ages of 40 and 50, it is only 1 in 1,910 people; therefore, it is not cost-effective. So it does not matter if you have breast cancer between the ages of 40 and 50, we do not think the government ought to be paying for your mammogram and we do not think anybody ought to have one. Well, that is fine for all those people who do not have breast cancer. It is terrible for the people who do have breast cancer and it could be found early with a mammogram.

So we rushed in here and we offset what that task force did. But they are going to be doing it time and time again. And is the Congress going to truly—every time they make a decision based on cost-effectiveness, not clinical effectiveness, are we going to reverse it? We are not. So there is another proof that we are, in fact, going to use the rationing of care to control costs.

Mr. BURR. Madam President, will my colleague yield for a question?

Mr. COBURN. I would be happy to.

Mr. BURR. If, in fact, the Congress did reverse the decision of an advisory board, what does that do to the budget deficit? And what does it do to the claims that this current bill being considered is paid for?

Mr. COBURN. I am not sure I can answer the question. But it would make it less effective in terms of supposed claims.

Mr. BURR. So if the authors of this bill never intended to make cuts, then it blows the budget neutrality that is portrayed in this bill. But if they use all the mechanisms that are in place to make sure reimbursements are cut or the scope of coverage is affected by a decision to limit one's care, then we could see prevention cut, wellness programs cut, or even the preventive diagnosis such as for breast cancer limited to a much smaller group.

Mr. COBURN. I think the Senator from North Carolina is really going to where I am going to get to later; that is, what is the motivation for the decisionmaking? I think my colleagues on the other side of the aisle are well intended, but I don't think they are well informed about the consequences of their intentions.

So if you set up the Task Force for Preventive Health Services and say you are going to rely on it, but we know they are going to make the decisions based on cost-effectiveness, not clinical effectiveness, what we are going to see is the American Cancer Society coming again and again and again because what we are going to do is we are going to cover those where it is cost-effective but not clinically effective. For 80 percent of Americans, they are not going to notice the difference, but one out of five Americans is going to notice the difference.

The second area, which I wish to spend some time on because we have actually modeled it after England, is cost comparative effectiveness. We ought to talk about what is comparative effectiveness research because there is nothing wrong with the research. It is health care research comparing various drugs, devices, and treatments head to head, and the whole goal of that is to find out what works best and what costs the least.

The assumption in this bill is, we can have 24 or 36 people in Washington decide that. In the Framingham studies they have been running for over 50 years on heart disease, we still don't have the answers and we have been studying it for 50 years. But we are going to be making decisions on cost, not on clinical effectiveness, which is going to limit your ability to have what you and your doctor think you need.

So we are going to pull out clinical experience of individual physicians. We are going to eliminate the heart of medicine, which is the combination of vast experience, gray hair, long years of training, family history, clinical history and physical exam and we are going to say: No, it doesn't matter. We are going to say: Here is the way you are going to do it.

Who uses comparative effectiveness research? Well, several countries do. When I share with my colleagues the stories about how it is used, you are going to get a real vision of what is coming with this bill—a real vision.

This bill creates a new agency called the Patient-Centered Outcomes Research Institute to perform comparative effectiveness research. I have already said the idea behind it is good. I strongly support medical research. I strongly support helping doctors and their patients choose the best research and the best treatment. The problem is, this bill doesn't do that. On the contrary, this bill will empower the government to decide which treatments you can have and which ones you cannot have. That is what this does. This removes the judgment of the doctor and replaces it with the judgment of the bureaucracy in Washington. It is not a hypothetical concern, it is a real-world problem.

In Britain, they control health care costs by denying or delaying access to expensive therapies. That is one of the reasons this country has one-third better survival for every cancer you can imagine over Great Britain because we don't do that. As a two-time cancer survivor I am acutely aware as a patient, not as a doctor, in that I want to make sure for my family and my patients they have the best alternatives, not the cheapest, because the cheapest alternatives are the ones that take years away from your life.

I am going to go through some examples. Nobody can dispute this is what is happening now and what will happen under our program. To Senator BAUCUS's credit, he had a bill that wasn't cost comparative effectiveness; he had one based on clinical comparative effectiveness. That is not in here. What is in here is cost comparative effectiveness. Senator BAUCUS knew you don't want to use cost as the main thing; you want to use clinical outcomes as the No. 1 deciding agent in how we approach health care—not cost—because if you only look at cost, nobody in this country would get a mammogram between 40 and 50. But this bill is different from what Senator BAUCUS had offered in his Finance Committee markup.

There is an agency in Great Britain called the National Institutes for Health and Clinical Excellence. It is pronounced NIHCE. Here are some of the decisions of NIHCE in the most recent years. They have a problem in England with cost, too, and they have a single-payer, government-run system. They have the government running it, but they still can't control their costs, so what have they done?

They have repeatedly denied breast cancer patients breakthrough drugs. They have forced patients with multiple sclerosis to wait 2½ years to receive new innovative treatments that people in this country are getting as soon as they are available. They have denied early stage Alzheimer's patients medication, requiring their condition to worsen before they give them the medicine. What do we know about the medicine? It works best when you have the slightest symptoms of Alzheimer's, not when you get worse. But that is the bureaucratic thinking: We will save money rather than practice good medicine.

They deny life-prolonging treatments to kidney cancer patients. They denied new medicine to all but a small percentage of patients with osteoporosis and then only as a last resort. In other words, you have to about have your bones breaking by standing before you get medicine for osteoporosis in Great Britain. In this country, we have prevented millions of hip fractures through effective medicines to restore the calcium and bone matrix in seniors' bones. But we have Medicare now saying you are doing too many tests to check on that, so you can only do it every 2 years. So we are going to use rationing, and we are.

They denied access to the only drugs available to treat aggressive brain tumors. They denied effective drugs to bowel cancer patients, colon cancer.

Macular degeneration is something that affects a large number of people in this country. That is where the macula—the area that actually allows you to see and concentrate your vision—as we age, we have what is called cystoid macular degeneration or dry degeneration. That is a disease of the eye where it causes vision loss. NIHCE required patients suffering from macular degeneration to go blind in one eye before they could have the medicine that almost every American who has macular degeneration in this country has. She had to go blind first in one eye before you could ever get the medicine. That is a bureaucrat making this decision or a bureaucratic committee because it was cost-effective to allow you to live with one eye. Elderly patients went to court to fight for drugs to keep them from going blind. Twenty-two thousand Britains became totally blind through that ruling by the NIHCE. In one case, an 88-year-old World War II veteran and former Air Force pilot sold his house to pay for the drug after the government said they weren't going to pay for it. The Royal National Institute of Blind People said that as a result of NIHCE's decision, countless people have either been stripped of their sight or stripped of their life savings to pay for private treatment.

For Alzheimer's, they ruled that three drugs, common to many people who are listening today—Aricept, Reminyl, and Exelon—were not cost-effective for patients with early Alzheimer's disease. Well, those are the only ones they work effectively on. One hundred thousand Alzheimer's patients a year were denied treatment that could have slowed the progress of their disease. The British Alzheimer's Society said this decision was disgraceful and victimized the most vulnerable in our society.

Brain cancer. Gliadel and Temodal were not cost-effective for treating brain tumors and severely restricted their access to them. A 47-year-old woman sold her house to buy the drug the government refused to provide. They have been held as the biggest breakthroughs in treating brain tumors in the last 30 years. Finally, in April of the year before last, they finally relented and allowed brain cancer patients to have the drugs that were available on the market.

Erbitux, very effective in resistant colon cancers. In 2006, denied. Seventeen thousand Britons a year get the sort of advanced colon cancer that Erbitux is designed for. Yet they can't have it.

Mr. BURR. May I ask a question of my colleague? Listening to this list of products that have been denied people in Great Britain, and certainly this is true in some other countries, makes me look at the Medicare population in this country with the realization that the way Medicare was constructed, a senior can't pay out of pocket because no provider can receive a payment from a senior. If for some reason this bill were passed and you took part of the arsenal of drugs away from seniors or procedures away from seniors, how can a senior get a benefit if no provider can receive an out-of-pocket payment from a senior?

Mr. COBURN. That is the problem with our system today. What we are going to hear them say is the insurance companies do this now. At first, for new treatments, until they are proven effective, most insurance companies don't cover them, but they cover them much sooner than Medicare does today. Today, Medicare is the last to approve the drugs.

We are going to hear that is not any different than the limitations from insurance. That is true. We need to change that. But the fact is, we are getting ready to put all these people into insurance programs, and then we are going to have the Federal Government, which is just as bad or worse than the insurance company, making those decisions.

I wish to finish my point on cost. We get two ways for fixing cost because that is what is keeping people from getting access. We can either ration it—and there are three methods to rationing in this bill which will be used—or we can incentivize outcomes and we can incentivize prevention and we can pay, based on the transparency of outcomes and quality. We haven't done any of that in this bill. We have said we have, but when you look at how do you prevent it—and the model is the 200,000 employees at Safeway and what they have been able to do in using their incentive systems to pay for prevention, to use competitive purchasing to reconnect the employee with the purchase of health care.

I understand my colleague from Nebraska is here, and I will yield to him because I understand he was a unanimous consent request.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNS. Madam President, I appreciate the courtesy extended by the Senator from Oklahoma.

I ask unanimous consent that the pending substitute amendment be modified to delete the following special carve-outs: eliminating or reducing the Medicaid unfunded mandate on Nebraska, Vermont, Massachusetts; exempting certain health insurance companies in Nebraska and Michigan from taxes and fees; providing automatic Medicare coverage for anyone in Libby, MT; earmarking $100 million for a health care facility, reportedly, in Connecticut; giving special treatment to Hawaii's disproportionate share of hospitals; boosting reimbursement rates for certain hospitals in Michigan and Connecticut; and mandating special treatment for hospitals in frontier States such as Montana, South Dakota, North Dakota, and Wyoming.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Madam President, I appreciate the Senator's desire to want to cut the payments to his own State, but I object.

The PRESIDING OFFICER. Objection is heard.

Mr. JOHANNS. Thank you. I yield to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, we had a very early vote, and it brings the health care reform bill obviously one step closer to final passage—at least it looks obvious that is going to happen. Regardless of whether the other side has 60 votes, my friends on the other side still have a problem they want to not have the public concentrate on; that is, that the pending bill still raises taxes on middle-income Americans. The Reid modification did nothing to reverse this fact.

I will take a few moments to illustrate the winners and losers under the bill. We start with a question: If a person is not receiving a subsidy for health insurance under the bill, then how can the person receive a tax cut? This is a relevant question because the White House and the majority leadership continue to proclaim that the bill is a ''net tax cut'' for middle-class Americans. For example, on Wednesday, December 16, a senior White House aide wrote:

> The bill being considered represents a substantial net tax cut for middle income families.

So I think that statement begs more questions. Who do you believe? The

White House, on the one hand, or on the other hand, the nonpartisan independent experts upon whom we on Capitol Hill rely for judgment—the people who are not political, the Joint Committee on Taxation?

This committee tells us that in 2019, a little more than 13 million individual families and single parents would receive the government subsidy for helping people under 400 percent of poverty buy health insurance. The Joint Committee also tells us that the number of tax filers in 2019 will be 176 million people. If people are wondering why we talk about 2019, it is the budget window from now until the end of the 10-year period of time that we call a ''budget window.'' That means out of—comparing this 13 million to the 176 million taxpayers, 13 million people receiving the subsidy and 176 million tax filers—that means out of that 176 million individuals, families, and single parents, only 13 million of them would receive a government subsidy for health insurance. That is only 7 percent of the tax filers. It is pretty important to understand that only 7 percent of Americans will benefit from the subsidy for health insurance.

We have a pie chart so people can see exactly what I am talking about. This says 176 million taxpayers, with 13 million receiving the subsidy. This means 163 million families, individuals, and single parents—or 93 percent of all taxpayers—will receive no government benefit under the Reid bill. What does that mean? It means there is a small beneficiary class under the Reid bill—7 percent. Thirteen million people will receive benefits under the Reid bill. A very large nonbeneficiary class—93 percent—will not benefit.

This nonbeneficiary class is affected in other ways. Yes, while one group of Americans in this class would be unaffected, another group of Americans will see their taxes go up. This group would not have a tax benefit to offset the new tax liability. That means these Americans will be worse off under the Reid bill.

It is legitimate to ask, for these 93 percent of the people, what happened to their net tax cut? What they will see instead is a net tax increase. Based on the Joint Committee's data, in 2019 42 million individuals, families, and single parents with incomes under $200,000 will see their taxes go up. This is even after taking into account the subsidy for health insurance. Again, this is on a net basis.

If we were to identify those Americans who are not eligible to receive the tax credit and those whose taxes go up before they see some type of tax reduction from the subsidy, this number will climb to 73 million Americans. The first bar on the chart illustrates what we have already established but looks at Americans earning less than $200,000. Right here, 13 million families and single parents and individuals would receive the subsidy.

The middle bar on the chart shows the net tax increase number of 42 million Americans under $200,000-a-year income. Finally, when we identify those Americans who get no benefit under this bill, and those Americans who see a tax increase, we find that there are 73 million individuals, families, and single parents under the $200,000 category. That is this group.

I want to close by referring to a final chart that illustrates the winners and losers under the Reid bill. What we see is that there is a group of Americans who clearly benefit under the bill from the government subsidy for health insurance. This group, however, is relatively small—8 percent of Americans, if you look at those earning less than $200,000.

There is another much larger group of Americans who are seeing their taxes go up. This group is not benefiting from the government subsidy, this group on the chart. There is another group of taxpayers who are generally unaffected, this 82 million here. The Joint Committee on Taxation tells us this group may be affected by tax increases that are not included in this study, like the cap on flexible savings accounts and the individual mandate tax that people are going to pay if they don't buy health insurance.

The bottom line is this: My friends on the other side of the aisle, first, cannot say that all taxpayers receive a tax cut; two, they cannot say the Reid bill does not raise taxes on middle-income Americans because we have the professionals who are nonpolitical at the Joint Committee telling us differently. No one can dispute that data.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. GRASSLEY. Madam President, my friends on the other side of the aisle continue to argue that the Reid bill eliminates the so-called hidden tax. They argue that this would reduce the cost of health care. For example, on Wednesday, December 16, a senior White House aide wrote:

> Even if you believe that some of the tax on insurance companies is passed along, it would be more than outweighed by the benefits middle-class families would get from reducing the hidden tax they currently pay for the uninsured.

I don't believe the fees on health insurance companies will be passed through to the policyholders. I think it is just idiotic not to think they would not be passed through.

I want to flatout state I know they are going to be passed through. My authority for this is the Congressional Budget Office and the Joint Committee on Taxation telling us that fact. The CBO and the Joint Committee on Taxation told us that these fees will actually increase health insurance premiums. Premiums will go up because the companies are paying increased taxes under this bill. For insurance premiums to go up, under a title of a bill that encompasses health care reform, that is going in the wrong direction. Also, for argument's sake, let's assume my Democratic colleagues are correct and this so-called hidden tax that results from uncompensated care equals $1,000. The pending health care reform bill still leaves a large number of Americans uninsured. Specifically, the Reid bill leaves 23 million out of 54 million without health insurance at the end of this budget window, 2019. So, at best, the Democrats' reform cuts the hidden tax in half—in this case, to about $500 a family.

To add insult to injury, however, the bill adds new hidden taxes. These taxes are the fees imposed on health insurance. CBO and the Joint Committee on Taxation—two respected organizations—say this will increase costs. If you check the report, no one can dispute that. These fees go into effect in 2011—still 3 years before any of the major reforms under the pending bill kick in.

That means this hidden tax will increase premiums in 2011, 2012, and 2013. That is before there is any government assistance for health insurance being provided to families that need it. The new hidden tax is also created as a result of the Medicaid expansion on the one hand, and Medicare cuts on the other hand, a major cost shift in health care derived from government programs—Medicare and Medicaid—which reimburse providers at rates roughly 20 percent to 40 percent lower than private providers.

President Obama understands that paying doctors below market rates leads to cost shift. This is what he said at a townhall meeting on health care reform:

> If they are only collecting 80 cents on the dollar, they have to make that up someplace else, and they end up getting it from people who have private insurance.

The Medicare and Medicaid cost shift will be increased significantly under the pending health care reform bill. According to the CBO estimate, Medicaid will be increased by more than 40 percent, from 35 million to 50 million people. Additionally, the bill includes almost $½ trillion in Medicare cuts that will result in lower payments to providers.

Increasing the current Medicare and Medicaid cost shift as a result of the Democrats' health reforms would add even more costs to a family's health insurance policy. The easier cost shift to address would be the $1,700 cost shift from defensive medicine. The Democrats do not address the cost shift from defensive medicine which former CMS Director Mark McClellan has estimated adds $1,700 in additional cost per average family.

Addressing this reform alone could save more than covering all of the uninsured in America.

So, you see, my friends on the other side say their bill will eliminate the so-called hidden tax. My friends seem to come up short on that one. Also, they add new hidden taxes that will burden middle-class Americans.

I think in the present situation, the legislation before us and the language used by debaters on the other side, they should be transparent when they are talking about getting rid of the hidden tax. The pending health care reform bill makes things from these three perspectives work.

Madam President, I will be happy to yield the floor for a minute for the purpose of a colloquy with Senator BAUCUS on another subject.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I would like to address a colloquy with Senator GRASSLEY, as he said, on another subject that is not related to this bill.

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

EXPIRING TAX PROVISIONS

Mr. BAUCUS. Madam President, the Senate is wrapping up legislative business shortly, but there are a few expiring tax provisions that have unfortunately not been extended. These provisions include tax benefits for individuals and businesses. These provisions would help teachers who purchase supplies for their classrooms and families with college students.

Further, a great number of U.S. businesses rely on important tax benefits, such as the research and development tax credit and the active financing exception, both of which expire at the end of this year. The energy industry also relies on several provisions that expire on December 31. Unfortunately, this is not the first time we have allowed important tax benefits to expire. As soon as the Senate reconvenes next year, my intention is that we take up legislation to extend these important provisions.

That is why Senator GRASSLEY and I have written a letter to the Senate leadership. I ask unanimous consent to have this letter printed in the RECORD.

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

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC, December 22, 2009.

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

DEAR MAJORITY LEADER REID AND REPUBLICAN LEADER MCCONNELL: We write to inform you that early in the next year, we intend to address the extension of various tax provisions expiring on or before December 31, 2009. We intend to extend the provisions without a gap in coverage, just as the House did on December 9th of this year. The legislation will extend several important tax benefits to individuals and businesses. The legislation will also extend a number of energy tax provisions, including the biodiesel tax credit, and natural disaster relief.

These provisions are important to our economy—not only because they help create jobs, but also because they are used to address pressing national concerns. We understand that the expiration of these provisions creates uncertainty and complexity in the tax law.

Taxpayers need notice of the availability of these provisions to fully and effectively utilize the intended benefits. We hope to address this issue as soon as possible to cause the fewest disruptions and administrative problems for taxpayers and also generate the greatest economic and social benefit.

Sincerely,

MAX BAUCUS,
Chairman, Senate Committee on Finance.
CHUCK GRASSLEY,
Ranking Member, Senate Committee on Finance

Mr. BAUCUS. Madam President, the letter states our intention to work together to get the extenders done as quickly as possible in the new year.

Senator GRASSLEY and I both understand that expiration of these provisions creates uncertainty and complexity in the tax law. Taxpayers need notice of the availability of these provisions to fully and effectively utilize their intended benefits. Finally, we must act quickly to cause the least disruptions and administrative problems for the Internal Revenue Service.

I hope when the Senate convenes early in 2010, we can address these expiring provisions as soon as possible. I wonder if that is also the intention of the my good friend from Iowa, Senator GRASSLEY.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I would like to add to what Senator BAUCUS said by speaking positively on this issue and to remind my colleagues who maybe have been watching in the last 3 weeks and have seen Senator BAUCUS and I on opposite sides of the issue of health care reform—it is uncharacteristic for us to have different points of view on legislation. In the 10 years he and I have been leaders of the Finance Committee, most of the issues coming out of our committee have been very bipartisan. What he just talked about and what I am going to respond to is one of those issues.

I agree with Chairman BAUCUS that we should retroactively extend the expiring tax provisions as soon as possible after Congress reconvenes in 2010.

As chairman of the Finance Committee in 2005, I worked with then-Ranking Member BAUCUS, and we authored the biodiesel tax credit.

The biodiesel tax credit is a tax credit that is needed to be extended before the end of the year to prevent the U.S. biodiesel market from grinding to a halt on January 1, 2010. This tax credit differs from other tax provisions in that the price of biodiesel will be $1 higher on January 1, 2010, as a result of the tax credit not being extended before that date. That means people will simply buy petroleum diesel rather than biodiesel come January 1, 2010.

I point out that support in Congress for extending the biodiesel tax credit, I think, has been and still is robust, bipartisan, and bicameral, and that it has not been extended prior to January 1, 2010, due solely to issues unrelated to the merits of the biodiesel tax credit.

I want everybody to know that I agree with Chairman BAUCUS that the expiration of these tax provisions creates uncertainty and complexity in the tax law. I also agree that the taxpayers need notice that these tax provisions will be in place so they can plan their personal and business affairs to fully and efficiently use the intended tax incentives.

In addition, extending the tax provisions as early as possible in 2010, as we intend to do, will minimize the administrative problems created for the Internal Revenue Service.

I look forward to working with Chairman BAUCUS to retroactively extend these provisions as soon as possible when the Senate reconvenes in 2010.

Mr. BAUCUS. Madam President, I thank the Senator for his statement. I look forward to working with him and other Senators so we can pass this legislation as soon as possible next year.

Again, I commend my colleague and friend. It is true that much more often than not we are working on the same side of an issue. Even on the few occasions when we are on the opposite side, I do say we do it agreeably. I wish more of the Senate would act the same way.

Mr. HARKIN. Madam President, I thank the Senators. The delay in the passage of the Tax Extenders Act of 2009 will cause problems for a wide variety of groups, as the distinguished Senators from Montana and Iowa have outlined. I believe the negative impact of our failure to act this year will be felt first, and felt most strongly, by manufacturers of biodiesel. Without the immediate passage of legislation to extend the biodiesel tax credit, a large number of biodiesel manufacturing plants are likely to close down because they do not have the resources to operate without the financial benefit of the credit.

Biodiesel is a key part of our Nation's success in biofuels. These biofuels, produced here in our own country, are helping to reverse our near-total dependence on petroleum for transportation in this country. The hard truth is that we get about 70 percent of our petroleum from other countries, and many of those countries are unstable or are unfriendly to the United States or both. So biodiesel is helping us restore national energy security.

Biodiesel is made from vegetable oils or animal fats. The biodiesel industry employed over 50,000 workers and added over 600 million gallons of biobased fuel last year to help power the diesel engines across our Nation and throughout the economy.

However, this is still a very small and struggling industry. It is absolutely dependent on continuation of

the biodiesel tax credit. Without this credit, most of the biodiesel plants in this country will simply be forced to shut down, thus idling important domestic fuels production capacity as well as putting as many as 20,000 employees out of work. We can't let that happen. And, if for any reason the credit was not made retroactive, bankruptcy would in a good number of instances be a quick result.

I do appreciate the efforts by the chairman and ranking member to move forward with this badly needed legislation at the first opportunity.

Ms. STABENOW. Madam President, as we work toward economic recovery, it is imperative that we act quickly to extend critical tax provisions scheduled to expire this year that promote research and development, spur community development, support the deployment of alternative vehicles and fuels, and provide certainty for businesses and families.

Knowing these tax provisions are in place allows Americans to plan for the upcoming year. The longer we wait to pass this legislation, the more uncertainty we place on businesses during a time when they are starting to recover. Many of these tax provisions encourage investment, the development of new technologies, and business growth, which allow our companies to be competitive in a global marketplace.

Delaying the extension of the research credit could put more than 100,000 jobs and billions of dollars in economic activity and Treasury revenue expected in 2010 in jeopardy, according to estimates from TechAmerica. If the credit is renewed, the association estimates that 120,000 jobs would be generated and/or sustained, there would be an additional $16 billion in additional research and development and other economic activity and $13 billion in Federal tax revenue over the course of 2010. However, for every day that the credit is left expired, there is the potential to lose 331 jobs, $45 million in economic activity, and $37 million in tax revenue.

Another important tax provision set to expire this year allows businesses to write off the expenses of cleaning up brownfields, industrial land that would otherwise continue to be a blight on our communities and harm our environment. In my home State of Michigan, these credits will be needed more than ever to address the brownfields that have been left behind as a result of the restructuring of the automotive industry. Revitalization of these brownfields will be critically important to communities throughout the State and the Midwest.

It is also imperative that we restore the estate tax retroactively to January 1, 2010. I am extremely disappointed that an extension was blocked and that the estate tax will be allowed to expire in 2010. Contrary to Republicans' claims, more heirs of farm and business estates will be hit with a tax increase than if we extended the estate tax at current levels. If the 2009 rules are retroactively applied, then only approximately 6,000 estates would pay the estate tax each year; however, if the estate tax expires, then it is estimated that 61,000 estates could be hit with the capital gains tax. It is critical that we extend the estate tax under the 2009 parameters to protect small businesses and family-owned farms, continue the incentive that the estate tax provides for charitable giving, and provide certainty for the heirs of farm and business estates.

During one of the most challenging economic times our country has faced, dragging our feet on these tax extensions could have a substantial impact on our Nation's businesses and families at a time when we should be doing all we can to help them succeed. I look forward to working with Chairman BAUCUS and Ranking Member GRASSLEY to retroactively extend expiring tax credits expeditiously when we return next year.

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

The PRESIDING OFFICER. The clerk will call the roll.

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

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

Mr. GRASSLEY. Madam President, there was a report released recently by the Chief Actuary, Rick Foster. I hope this report will once and for all put an end to any serious consideration of the CLASS Act. The CLASS Act is going to be in the bill, if this bill passes Congress. But it should not be in it, and we should have had a long discussion on this provision because it is simply fiscally unsustainable.

The information the Chief Actuary's letter provides is ample evidence of why the CLASS part of this bill cannot work. Quoting from page 13 of the Chief Actuary's letter:

> We estimate that an initial average premium level of about $240 per month would be required to adequately fund CLASS program costs for this level of enrollment, antiselection, and premium inadequacy for students and low income participants.

So who would enroll in the CLASS program? An American making 300 percent of poverty has a gross income of $32,490. If the CLASS premium is, as the Chief Actuary predicts, $240 per month—that is $2,880 per year—and an individual at 300 percent of poverty would have to commit 8.9 percent of their income to join the program. That is simply not possible, nor is it plausible to argue that young, healthy persons will commit almost 9 percent of their income to long-term care insurance policy.

The people who will enroll then are those who have real expectations of using the long-term care benefit. People who join the CLASS program with the expectation of needing the benefit become the Bernie Madoffs of the CLASS Act Ponzi scheme.

An individual becomes eligible for the CLASS program after paying premiums for just 5 years. If a person pays premiums of $2,880 per year for 5 years, they would have paid a total of $14,400 in premiums for that program. That person can then begin collecting a benefit of $1,500 per month. In 10 months, the person will have recouped their 5 years' worth of premiums.

This simple explanation should make it crystal clear why the CLASS Act is a fiscal disaster waiting to happen, not based on our determination but based on the determination of the Chief Actuary. The premium will be too expensive to entice young, healthy people to participate. The benefit payout is very enticing for people who know they will need the benefit. Healthy people do not participate; sicker people will. This adverse selection problem will send the program into the classic insurance death spiral.

The Chief Actuary concluded on page 14 of his report with this one sentence:

> There is a very serious risk that the problem of adverse selection would make the CLASS program unsustainable.

If the CLASS Act becomes law, the Federal taxpayers are at very serious risk of paying a price to clean up the fiscal disaster when the CLASS Act fails.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. 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. BAUCUS. Madam President, this chart shows very graphically—this is data put together by the Joint Committee on Tax, combining all the various provisions in the bill. Basically, it shows that in 2015—that is the bar on the far left—there will be a $26.8 billion net tax cut for individuals—net tax cut. Two years later in 2017—that is the middle vertical bar—there is a net tax cut of $40 billion for all Americans—a net tax cut. Not for all Americans. Some will not get it, but most Americans by far will. Then, of course, 2 years later in 2019, there is a net tax cut of $40.8 billion.

I wanted to make it clear that there is a net tax cut in this bill, according to Joint Tax. This is the distribution over 3 different years—2015, 2017, and 2019. That is information prepared by the Joint Committee on Tax. I want Americans to know there are tax cuts in this bill, and they are very significant.

Madam President, I yield the floor.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 2:30 p.m.