

the total benefit for the Nation. It could be an additional cost that the port will have to pick up. Okay. But we get a twofor. We get environmental benefits as well as the economic benefits to the port.

Have you got any other things on your list?

Mr. ENYART. I will just close out with saying, Mr. GARAMENDI, thank you for the time this evening. I think this has been a true team effort from manufacturers and business groups, labor unions, port authorities, and the Agriculture Committee.

You know, I sit on the Agriculture Committee, and the ag community knows how critical this legislation is for Illinois. And Congress needs to get things done for the American people, and no job is more important than keeping our economy strong right here at home.

Mr. GARAMENDI. General Enyart, Congressman ENYART, or Bill, thank you so very, very much. I really appreciate working with you tonight on this critical issue, the fundamental investment.

Let's remember, this is not new. The Army Corps of Engineers has been around since the very earliest days of our democracy. The Army Corps has been responsible for the waterways of America, and the Water Resources Reform and Development Act is going to be an opportunity for America to really move its infrastructure, particularly the trade.

Remember, just to review, we are talking 13 million jobs immediately depend upon the Water Resources Reform and Development Act. We are talking about 99 percent of our trade travels through our ports and waterways, whether it is on the Mississippi, the Sacramento, the San Joaquin Rivers, or the great ports and the coastal part of America. It is critically important.

And as we do these things, we have the opportunity to reach back into the history of America and remember what the Founding Fathers talked about way back in George Washington's very early days: that these fundamental investments in what they called canals and ports and roads were critical to the growth of the United States at the very, very outset. George Washington and Alexander Hamilton also recognized the importance of international trade and that we get those trade policies correct.

So as we get ready to do the Water Resources Reform and Development Act, which is critical—and the conference committee starts tomorrow, and I have the honor of being on that conference committee—we also think about the way in which the trade of America is dependent upon our work in getting sound policies in place.

And it is also critically important in dealing with the issue of international trade agreements, whether it is the transpacific trade program or the new one that is being worked on with Europe, we have to protect our own jobs.

We have to protect the American economy. And in doing so, we must carry out our constitutional responsibility given to us by the United States House of Representatives and the Senators. The Constitution says that it is the legislature, Congress and the Senate, that shall set trade policy, and that requires that we have the opportunity to look at the details of every trade policy and not fast-track trash through the House.

Joining me and taking up, as I wrap up my hour, is my colleague on the Republican side. Why don't you take my last couple of minutes, and then you can have your own half hour.

Mr. FORTENBERRY. Well, first of all, let me thank the gentleman for yielding to me. I know it is a bit unusual when Democrats and Republicans come down and share portions of the time. I think it is actually what the American people want a little more of. We should do this more often.

I am giving a talk in a few moments on health care. You and I will probably disagree to some fundamental philosophical approaches to that, and that is fine. You are in one party; I am in another. You have your own inclinations; I have my own inclinations and approaches. But to try to work constructively toward problem solving, I think it would behoove us all if we could figure out a better pathway to do that.

And that is why I am grateful to you for just leaving me a few moments because as I was listening to your speech, you talked about something I didn't know, that George Washington refused to wear a suit made in England and went back and said, Give me a manufacturing policy for this country. It was a very curious but good story to demonstrate a particular dynamic that, as you rightly pointed out, is part of our modern-day debate about how we do trade agreements in this fast-track authority. I think we have to be very, very cautious about this.

Trade can have the potential benefit to raise all boats. It has to be fair. It has an element of free, but it also has to be enforceable. And there are other dynamics to trade other than just the economic benefit that should be measured, such as the human cost of production in various societies. And we have glossed over those things in the past.

So I just wanted to commend you and thank you for raising this issue of giving, basically, over our authority by saying, we will vote to deny our authority to review the fullness of a trade agreement should one come through to us. I think that is a serious concern. So I want to commend the gentleman for raising the issue.

Mr. GARAMENDI. Well, thank you so very much. And I look forward to working with you on that issue. I know it is going to be coming.

Well, we don't know exactly when. But they are trying to wrap up. Our trade rep, our ambassador is trying to

wrap this up and present it to us. And they are talking fast-track. And I am going, time-out, guys. Time-out. We need to review. We need to make sure that it is fair trade. Not just free trade, but fair trade—fair to the American worker, fair to the American manufacturer, farmer, and the like.

Mr. FORTENBERRY. If I could add something, I think we ought to call it "smart" trade.

Mr. GARAMENDI. I like that word, too. Can we compromise on that?

Mr. FORTENBERRY. Yes, sounds good.

Mr. GARAMENDI. I yield back the balance of my time.

#### HEALTH CARE

The SPEAKER pro tempore (Mr. DESANTIS). Under the Speaker's announced policy of January 3, 2013, the Chair recognizes the gentleman from Nebraska (Mr. FORTENBERRY) for 30 minutes.

Mr. FORTENBERRY. Mr. Speaker, thank you for the time.

I don't have to tell you all that there is a debate raging in our country about the future of health care. I want to share, first of all, a story that I received by email from Yvonne who lives in the town of Firth, Nebraska, right near me. She says this:

We are a farming family of five in southeast Nebraska and recently received notification from Blue Cross/Blue Shield of Nebraska—an insurance company—that our insurance premiums are increasing from \$578 per month to \$1,092 per month. That is \$514 more, resulting from the misnamed "Affordable Care Act."

Yvonne goes on and says:

Even if I play with the numbers and drop our family income to be eligible for subsidies, my family has never needed government assistance in the past to pay for health insurance. Why should we need it now, other than Washington's interference? Would you please tell me how I am supposed to find an extra \$500 in my monthly budget to afford this new improved policy.

Mark, who lives in Lincoln, says he is 49. He said he had his insurance canceled, and he had a very good policy. And this is what he had to say:

I had a \$5,000 deductible policy; and after that, everything was covered. My policy was not a junk insurance policy. And it was canceled.

□ 1845

Mr. Speaker, many Americans are awakening to sticker shock and are feeling, frankly, very betrayed by the earlier comments that if you like your health care plan, you can keep it. Clearly, there is a significant problem here. And what has happened?

Well, Mr. Speaker, we need the right type of health care reform—health care that is actually going to reduce costs and improve outcomes while also protecting vulnerable persons. But what we have gotten instead through the new law is a shift of cost to more unsustainable spending by government, a shift of cost from one American to

another; and we also have a serious erosion of health care liberties.

This is another email that I received from Joan. She talked about her son. She has maintained her son's policy—a young man—in case of a catastrophic event so it would not be a burden to the hospital.

She said:

He does not make enough money to file taxes, but his premium goes from \$85 to \$220. So my son will no longer have insurance of any kind. My son's new policy is required by law to include things he can never, ever use—maternity for a male and pediatric services for an adult. Please at least allow the insurance carriers to call this what it is—an insurance subsidy from my son to others.

This young man is 30 years old. I don't know the circumstances of the family as to why they are providing a policy for their 30-year-old son, but clearly the family is trying to do the right thing and help one another; but they are being forced by escalating costs to reconsider the very idea of carrying health insurance themselves and doing the right thing.

Mr. Speaker, when I was a much younger man in my twenties, I had an individual insurance policy that I bought. I thought it was the right thing to do. I didn't want to impose the risk of my own health care needs—in case something went wrong—on the rest of society. And I bought this policy. It was a pretty big burden to carry for someone in their twenties. It was fairly expensive. So I decided to raise the deductible to \$1,000 to basically help better manage the costs.

Well, one day I had a very severe headache, and it just didn't seem to go away; and as this went on, I decided it was necessary for me to seek medical attention.

So thinking about it, I decided to simply bypass the family doctor, assuming that they would probably refer me to the ear, nose, and throat specialist. And so I made an appointment with the ENT doctor, probably saving myself about \$50 by simply going to the specialist.

When I got there, she examined me and they took an x-ray. Afterward, the doctor said, I really can't tell from the x-ray what the problem is. I'm going to need to do a CAT scan. I interrupted her at that moment and injected in the conversation and said, Doctor, I understand if you might be worried about liability and there might be this test that is normal protocol for you to run. She interrupted me and said, Why are you saying this to me? I said, Because I need to know if you really need this test. I'm actually paying for it.

Again, I had the \$1,000 deductible.

She said, Oh, let's think about this. I'm only looking at your sinuses. So that means that we could probably ask one of the two entities in town with a CT scan machine if they will widen the cross-section and let's see if they'll give you a discount for doing that.

So she asked her assistant to help. They called both places in town, found

out the price, found out if they would lower the price based upon a wider cross-section for this test, and one of them did. And I don't remember the exact amount, but I think it was \$75.

Mr. Speaker, I saved \$75 by simply asking a simple question. The doctor got the test that she needed and the community resource was more properly allocated, all because I had the incentive to watch the cost.

This is one of the problems here that we have in the whole health care debate. Because, again, the Affordable Care Act, sometimes called ObamaCare—and there are a lot of people who want to move away from that expression “ObamaCare,” and I respect that, because it has always seemed to me to be a bit disrespectful toward the President, so let's call it the Affordable Care Act. The Affordable Care Act shifts costs to more government spending and actually is moving costs from one individual to another.

Now, how did we get here?

Well, you remember in the Bush administration the number that was being talked about was that there were 50 million Americans who were uninsured. It has been a while now since I looked at that statistic. From memory, as I recall, that was actually an aggregate statistic that reflected the number of people within a year who had some trouble accessing affordable, quality health insurance. It was not necessarily a snapshot in time.

So the number might have been bigger than what was suggested, but it laid the ground work for where we are now. Of course, President Obama and the administration used that number as well; but when you parse the number down and look at Americans who were having problems accessing affordable, quality health insurance, whether because of preexisting condition or some other issue, that number may have come down to perhaps 10 million to 15 million persons.

Now that is a real problem. That is a lot of people who need help. And the right response is to engage in policy debate that will actually help them access affordable, quality health insurance; but we have done so by turning the entire health care system inside out. And it is creating havoc, sticker shock; and many Americans are feeling betrayed, particularly those who are buying their insurance in the open market, the individual market.

Soon, many more will be receiving the price shock who have employer-based insurance because of a couple of factors. And what are those factors?

First of all, in the new law what has happened is there is a shrinkage of the age ratio. It used to be six categories, as I recall—now it is three—by which you can price the product. That means younger people are actually subsidizing older people. You can have a debate about the merits of that, but that is one of the cost drivers.

Secondly, there are all types of new mandated benefits. You heard it in the

emails that I received. First of all, a very young man is having his insurance rates skyrocket simply because he is a young male. In Nebraska, we have one of the highest rate increases for single males. It is second only to Arkansas. It is 220-plus percent, as I recall.

Why is that? We were somewhat a less regulated State, if you will. But what that created were market conditions whereby a young person who was relatively healthy could get an affordable, quality health insurance policy that protected them from catastrophic incidents. If they were in an accident or an unfortunate disease happened to strike them, they were covered; but now it is pushing those policies to a level where people are questioning as to whether or not they can afford it. A policy designed to help people is hindering those who have been doing the right thing from purchasing insurance.

The mandated benefits issue: as the older gentleman writing me pointed out, I don't need maternity services. Again, those were incorporated into the law. An inability to customize an insurance policy based upon one's particular needs after us deciding what is a reasonable set of basic coverages that are necessary, which used to occur State by State.

The third is no denials. Now, this one is a little bit more sensitive because, again, we do have Americans who are being held by this law and who had previously been either denied because of preexisting conditions or, for one reason or another, were having problems accessing affordable, quality health insurance.

So as we move forward into a debate as to how we are going to reform the system and perhaps get this right, it is necessary that we carry forward either this way or another way. It used to be the government's subsidy of high-risk pools in which we allowed people to have access to more affordable insurance. Either that way or the way whereby we all absorb the cost across insurance policies and that we take care of people who rightfully need access.

And so there are a few embedded policies in this Affordable Care Act that do make some sense. The first one was allowing young people to stay on their parents' policies a little bit longer—until the age of 26. I supported that before the Affordable Care Act made sense. It replenishes your insurance pool, helps enculturate the concept of buying insurance at a young age, and hopefully that carries forward into creating a more robust, dynamic marketplace.

Second is, again, dealing appropriately with people who have preexisting conditions. There are a lot of ways to do that—either, again, by subsidizing the market directly, since it was somewhat broken, or absorbing the cost across all insurance products.

The third issue was removing insurance caps for those who actually

bumped up to their total maximum benefit.

I know of cases where families were struggling with a severe disease condition that would meet their insurance cap. The response was they simply had to leave their job and go find another job and get employer-based insurance to basically start the clock over. That doesn't save the system any money. It just burdens the family.

So those are three aspects of the current health care bill that makes some sense, but we did not have to do so by turning the entire system inside out and harming disproportionately large numbers of Americans who have been doing the right thing: protecting themselves and not relying on society for the imputed costs of their own health care risk; who were trying in a marketplace to find the right product for themselves, but now who have lost access to basic products like good catastrophic coverage, which will lower costs for younger people. That is a very strong disincentive for young people to actually enter the insurance market, and that needs to be corrected.

I think it is also part of our responsibility, for those of us who have said "no" to the Affordable Care Act and who have said there are better ways to reform the health care system to start laying out some specifics.

Well, one of the specifics should be that we all ought to try to agree that the health savings account idea is a way in which we form a hybrid model that actually benefits the marketplace, benefits individuals, and retains the robustness of what private market competition can give you.

Let's take, for instance, the case of the surgical procedure called LASIK. Now, I am not aware of insurance policies that regularly carry that procedure whereby the eye is operated on to correct vision. Large numbers of Americans have been helped by this extraordinary technological invention. And it appears to me from a cursory look at that market that prices have fallen, outcomes have improved, and the doctors who do this surgery seem to do pretty well with basically no insurance involved.

So let's look at the health savings account model as a hybrid model whereby we retain the government subsidy in a certain sense by allowing people to set aside an account on a tax-free basis and they accumulate monies that go toward their first dollar of health care costs, taking better control over those first dollars that are expended.

Now, Mr. Speaker, I recently had a medical issue. I had a sore spot on my ear. I didn't think much about it, but after about 3 weeks of it being there, I thought at my age maybe it is good to get that checked.

So I went to the dermatologist, and he looked at it and he said, JEFF, I think this is 50-50 it may be a cancerous-type condition. I said, All right. He said, I'm going to put you on a med-

icine that we can go ahead and get started now while we wait for the biopsy to come back.

So I went to the pharmacist to get the medicine. My co-pay was \$5. I am very grateful for that. It was very easy for me, and I am thankful I had the insurance to be able to do this. It was \$5.

I asked the pharmacist, How much does this medicine cost? He said, I don't know. Let me check. He came back and said, It's \$500. I said, Well, this is Friday. I'm not sure on Monday if I'm going to need this medicine or not. It's 50-50. Maybe we just ought to wait, and I chose to wait.

So on Monday the doctor called back and said it was benign—not cancerous—nothing to worry about, and I didn't have to take the medicine.

Well, I had no incentive not to take the medicine. The doctor didn't necessarily think through the question with me. He didn't have to because my co-pay was \$5. Again, I am grateful for that. But the point being that \$495 of waste would have occurred in the system had I not simply asked a question, and I didn't have an incentive to ask a question. I was simply trying to make sure that we weren't imprudently using that much medicine when it may go to waste; and I am glad I turned it down.

Again, that is the point. If you have your own health savings account, which is coupled with a catastrophic policy, two things are occurring at once: first of all, you are controlling your first dollar costs. You have a normal conversation with your doctor about ordinary health care. Is this the pathway we need to go? What are our alternatives? Who can provide those in town—maybe at a cheaper rate, with the same quality?

For that, we need price transparency in medicine. It is an important part of market reform that needs to occur. But if something really goes wrong and you are on the hospital gurney getting rolled into an operating room, you shouldn't have to pull off your mask and say, Can somebody give me the price of the anesthesia around here? That is not the point. That is different. That is a catastrophic condition. With catastrophic insurance, you should be protected from having to worry about those market dynamics.

So I think this is a good hybrid model whereby, again, the government incents you to put a little bit of money aside in a tax-free account which, by the way, can accumulate over time. Most people don't get sick in their life, and a lot of this money could grow to a substantial amount over time and actually be a supplement in retirement or a supplement to Medicare. We have got long-term cost problems in the Medicare program.

□ 1900

So, again, it is thinking dynamically, creatively as to how we restructure health care and give improved opportunities for a robust marketplace for health insurance that doesn't just con-

solidate the marketplace into fewer and fewer companies. It has been suggested that what is happening now is this is becoming like a utility system whereby there are going to be a few insurance carriers that work with hospitals, and that is it. The government will have a role in setting certain rates, and that is it. So you lose the dynamic of the competitive model for the insurance market. We should protect people's access. We should allow people to have access to affordable, quality insurance and not simply be denied for preexisting conditions. There are a lot of ways to do that. If we do that, we can keep the market dynamic basis for controlling health care costs.

We do this in all other areas of our lives, and it is normal to us. There is no reason that we have to put on blinders when we are dealing with ordinary health care costs and simply submit to the system whatever they tell us to do. There is no reason for that. What we could see—again, if we inject this sort of competitive marketplace for ordinary costs—is competition in the marketplace for ordinary processes and procedures in medicine, for drugs. Then you could see, like in the LASIK surgery example, prices falling, innovation occurring, and a health care system making reasonable returns for its efforts. Right now, we have a health care system that is very, very frightened. Doctors are very frightened of the next steps in terms of the evolving dynamic of the Affordable Care Act. You have many doctors who are saying they are not going to be able to afford to take on any more Medicare patients. You already have this problem in Medicaid. So you want a robust, dynamic market in which people are innovating, in which costs are falling, and in which health care outcomes are improving.

Health Savings Accounts give people the opportunity to control that first-dollar cost, but if they are really sick or have an accident, they are protected and don't have to worry about those costs. That makes a lot of sense to me, Mr. Speaker. In the Affordable Care Act, unfortunately, though, what we have is a dampening of the marketplace for the Health Savings Account idea. It ought to be exactly the opposite. Now, there is a reasonable argument that some have made that this is not appropriate for people who are older, who have increasing health care costs, and who don't have the time to set enough money aside to meet their normal, ordinary expenses—fair enough—but it is an important model that we should be eagerly embracing for the young generation so that they can have affordable, quality catastrophic insurance, so that they have incentive to move into the market, and so that the market responds to their questions as to:

Why does this cost this much? Who is providing the best service? Does this really make sense?

With our simply trying with the diminished marketplace and with a lack

of incentive to actually watch those first-dollar costs that the Health Savings Account gives us, then there are not really those incentives to, again, force transparency and to ask simple questions as to how you best manage the resources that you have in partnership with the medical community, like I did when I was trying to reduce my own costs for that CAT scan. The doctor very willingly accommodated my request, and that community resource was better allocated.

To me, that is a commonsense solution that we all ought to be embracing. Instead, what we have now is a huge shift of cost to more unsustainable government spending and to many Americans being disproportionately hurt because of skyrocketing premiums or because they are losing the health care that they were promised they could keep. Now, that is simply not fair. There is a better way to fix this system.

In the last few weeks, because of the problematic rollout of the marketplace Web site—the “exchange” as it is called—it has brought more and more attention to this issue. It is my hope, Mr. Speaker, that we just don’t get into finger-pointing and “we told you so,” for those of us who are against this, but that we actually sit down and try to construct something that is much more reasonable and fruitful for the entire system.

Mr. Speaker, the formal definition of a “law” is: an ordinance of reason given by those in authority for the common good. You have a real question here as to the reasonableness of this law, because it is so unfairly and disproportionately hurting a lot of people, and whether that meets the definition of its being for the common good.

As I suggested, there are aspects of the current law that we can retain—keeping young people on insurance longer, removing the caps on insurance, and protecting people who have preexisting conditions. Those should be retained, I feel; but as we move forward with a robust debate, we ought to keep in mind: let’s do everything—let’s do all we can—to give America a better path forward, the path that they deserve, so that any health care reform meets the true definition of a truly just law in that it promotes the common good, which means society’s well-being.

What does that common good look like?

It is a vibrant marketplace for affordable, quality insurance. Persons who have had a condition shouldn’t be denied. There should be a dynamic by which the person controls his first-dollar cost because he owns those dollars, and he is protected, if something really goes wrong, through catastrophic policies.

That shift to the health care paradigm could lend itself to the right type of reform for the next generation for Medicare, for instance. If you have had a huge savings account accumulate

over time because you are not one of the unfortunate—you are one of the majority of people who, fortunately, does not get stricken by something serious over your lifetime—then you will be able to potentially use that money for your own well-being and retirement or as a further supplement to the Medicare program.

This is what is called “thinking outside the box.” Let’s think dynamically as to how these programs can mutually reinforce one another—the current health care reform and our important health safety nets in retirement. That is what we ought to be thinking about.

So, Mr. Speaker, I just submit these comments this evening because I think it is important to try to unpack what has gone wrong and why and to frame the debate in a manner that is actually constructive so that America gets the type of health care reform that we deserve—a robust health care system that leads the world, that improves health care outcomes while reducing costs, and that also protects vulnerable persons.

Mr. Speaker, I yield back the balance of my time.

#### LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. THOMPSON of Pennsylvania (at the request of Mr. CANTOR) for after 1:30 p.m. today on account of official business.

#### ADJOURNMENT

Mr. FORTENBERRY. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 7 o’clock and 8 minutes p.m.), under its previous order, the House adjourned until tomorrow, Wednesday, November 20, 2013, at 10 a.m. for morning-hour debate.

#### EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XIV, executive communications were taken from the Speaker’s table and referred as follows:

3727. A letter from the Secretary, Commodity Futures Trading Commission, transmitting the Commission’s “Major” final rule — Enhancing Protections Afforded Customers and Customer Funds Held by Futures Commission Merchants and Derivatives Clearing Organizations (RIN: 3038-AD88) received November 18, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3728. A letter from the Director, Regulatory Review Group, Department of Agriculture, transmitting the Department’s final rule — Farm Loan Programs; Clarification and Improvement (RIN: 0560-A114) received November 12, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3729. A letter from the Associate Administrator, Department of Agriculture, transmitting the Department’s final rule — Irish Potatoes Grown in Washington; Decreased Assessment Rate [Doc. No.: AMS-FV-13-0010;

FV13-946-1 FIR] received November 14, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3730. A letter from the Chairman and Chief Executive Officer, Farm Credit Administration, transmitting the Administration’s final rule — Federal Agricultural Mortgage Corporation Funding and Fiscal Affairs; Farmer Mac Capital Planning (RIN: 3052-AC80) received November 12, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3731. A letter from the Under Secretary, Department of Defense, transmitting account balance in the Defense Cooperation Account as of September 30, 2013; to the Committee on Armed Services.

3732. A letter from the Associate General Counsel for Legislation and Regulations, Department of Housing and Urban Development, transmitting the Department’s final rule — Public Housing Capital Fund Program [Docket No.: FR-5236-F-02] (RIN: 2577-AC50) received October 30, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

3733. A letter from the Chairman and President, Export-Import Bank, transmitting a report on transactions involving U.S. exports to China Southern Airlines Co. Ltd. (China Southern) of Guangzhou, China; to the Committee on Financial Services.

3734. A letter from the Chairman and President, Export-Import Bank, transmitting a report on transactions involving U.S. exports to Korean Air Lines Co., Ltd. (KAL) of Seoul, South Korea; to the Committee on Financial Services.

3735. A letter from the Chairman and President, Export-Import Bank, transmitting a report on transactions involving U.S. exports to Bulgaria pursuant to Section 2(b)(3) of the Export-Import Bank Act of 1945, as amended; to the Committee on Financial Services.

3736. A letter from the Chairman and President, Export-Import Bank, transmitting a report on transactions involving U.S. exports to Minsheng Financial Leasing Co., Ltd. of Tianjin, China; to the Committee on Financial Services.

3737. A letter from the Chairman and President, Export-Import Bank, transmitting a report on transactions involving U.S. exports to Australia pursuant to Section 2(b)(3) of the Export-Import Bank Act of 1945, as amended; to the Committee on Financial Services.

3738. A letter from the General Counsel, Federal Housing Finance Agency, transmitting the Agency’s final rule — Removal of References to Credit Ratings in Certain Regulations Governing the Federal Home Loan Banks (RIN: 2590-AA40) received November 7, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

3739. A letter from the Acting Assistant Secretary for Special Education and Rehabilitative Services, Department of Education, transmitting the Department’s final rule — Final Priority. Rehabilitation Training: Rehabilitation Long-Term Training Program—Vocational Rehabilitation Counseling [CFDA Number: 84.129B] received November 12, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

3740. A letter from the General Counsel, Pension Benefit Guaranty Corporation, transmitting the Corporation’s final rule — Benefits Payable in Terminated Single-Employer Plans; Interest Assumptions for Paying Benefits received November 7, 2013, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

3741. A letter from the Secretary, Department of Health and Human Services, transmitting the second biennial report concerning the Food Emergency Response Network mandated by the FDA Food Safety