scheduled for 11:30 a.m. this morning occur at 11 a.m. this morning.

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

RESERVATION OF LEADER TIME

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

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will proceed to executive session and resume consideration of the following nomination, which the clerk will report.

The senior assistant legislative clerk read the nomination of Justin George Muzinich, of New York, to be Deputy Secretary of the Treasury.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

HEALTHCARE COSTS

Mr. ALEXANDER. Madam President, I ask unanimous consent to speak for up to 30 minutes.

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

Mr. ALEXANDER. Madam President, today I am asking experts at the American Enterprise Institute and Brookings Institute, as well as other leading experts, for specific ideas about how Congress and the President can work together to reduce the cost of healthcare in the United States. Here is why.

Last July, at the Senate HELP Committee's second in a series of five hearings on reducing healthcare costs, Dr. Brent James, a member of the National Academy of Medicine, testified that 30 percent—and perhaps as much as 50 percent—of all the money spent in this country on healthcare is unnecessary. That startled me, and I hope it startles you.

So I asked another witness, Dr. David Lansky from the Pacific Business Group on Health, if he agreed with Dr. James' estimate that 50 percent of all the money spent on healthcare is unnecessary. Dr. Lansky said yes.

Then, in our next hearing on reducing healthcare costs, not one witness on our distinguished panel disagreed with Dr. James. That means we are spending as much as half of all we spend on healthcare on unnecessary treatment, tests, and administrative costs.

As a country, we spend a huge amount on healthcare—$3.5 trillion in 2017, according to the Centers for Medicare and Medicaid Services. When we use Dr. James' estimates, that means we spent roughly $1 to $1.8 trillion on unnecessary healthcare in 2017. That is more money than the gross domestic product of every country in the world except nine. That is three times as much as the Federal Government spends on all of our national defense, 60 times as much as it spends on Pell grants for college students, and about 550 times as much as the Federal Government spends on national parks.

For the last 8 years, most of the debate about healthcare has not been about this extraordinary fact that we may be spending up to half of what we spend on healthcare unnecessarily. Instead, we have been arguing about health insurance. In fact, really, we have been arguing about 6 percent of the health insurance market—the individual insurance market.

The truth is, we will never have lower cost health insurance until we have lower cost healthcare. Instead of continuing to argue over a small percentage of the insurance market, what we should be discussing is the high cost of healthcare that affects virtually every American.

Here is something we ought to be able to agree on. We are spending too much on healthcare, and too much of what we spend is unnecessary. The five hearings we held reminded us of something else we should be able to agree on. One major reason for the unnecessarily high cost of healthcare is that the healthcare system does not operate with the discipline and cost saving benefits of a real market.

Too many barriers to innovation drive up costs, and most Americans have no earthly idea of the true price of healthcare services they buy, which also drives up costs. Let me repeat that. One major reason for the unnecessarily high cost of healthcare is, the healthcare system does not operate with the discipline and the cost-saving benefits of a real market.

Too many barriers to innovation drive up costs, and most Americans have no earthly idea of the price of the healthcare services they buy, so that also drives up costs. As a country—American families, American Federal and State governments, and private companies—we spent $3.5 trillion on healthcare in 2017, according to CMS, almost as much as we spent on the entire Federal Government in 2017, according to the Congressional Budget Office.

High healthcare costs impact everyone; first, the taxpayer because the Federal Government spends about one-third of all Federal dollars on healthcare. According to the Congressional Budget Office, of the $3.98 trillion the government spent in 2017, $1.1 trillion of that was mandatory spending for Medicare, Medicaid, and other healthcare programs.

This Federal Government runaway spending is the principal cause of the national debt. The principal cause of the national debt is not national defense, national parks, and the National Institutes of Health. The principle cause of the national debt is the runaway government spending on healthcare, which is squeezing the budget for national parks, national defense, and basic biomedical research.

Healthcare costs also impact States, all of which have to balance their budgets. When I was Governor of Tennessee a few years ago, Medicaid was about 8 percent of our State budget. That was in the 1980s. Today, it is 30 percent of Tennessee's State budget. That means States have less to spend on fixing roads, educating children, and helping adults and high school graduates get better job skills.

Second, healthcare spending adds to the cost of doing business in the United States. Warren Buffett has called the ballooning cost of healthcare ''a hungry tapeworm on the American economy.''

Third and most important, the rising cost of healthcare is squeezing the budgets of American families. According to the Gallup poll, 80 percent of registered voters before this midterm election rated healthcare as ''extremely'' or ''very important'' to their vote—a higher percentage than every other issue polled, including the economy, immigration, and taxes.

I imagine every Senator has heard stories from their constituents about struggling to stretch paychecks to afford prescriptions or to cover a surprise medical bill.

Any one of us who has received a medical bill in the mail has wondered, what am I actually paying for?

Here is a story I heard recently. Todd is a Knoxville father who recently took his son to the emergency room after a bicycle accident. His son was treated. Todd paid a $150 copay because the emergency room was ''in network'' for his health insurance, and they headed home. So Todd was surprised when he received a bill in the mail for $1,800 because, even though the emergency room was in network, the doctor who treated his son was not.

Todd wrote his Senator—me—trying to figure out why it is so hard to understand what healthcare prices really are. ''If I am expected to be a conscientious consumer of my own healthcare needs,'' he wrote, ''I need a little more help.''

The issue of surprise billing is a widely recognized problem. It was highlighted in a report from the White House on healthcare costs just this last Monday.

We want Americans like Todd and his son to be able to access quality care they can afford. So earlier this year, our Senate committee set out, in a bipartisan way, to see what we could find out about lowering healthcare costs. We held five hearings over 6 months.

In June, at our first hearing, we set out to better understand how much healthcare actually costs in the United

States to see if we could get some agreement on the numbers.

At our second hearing in July, we heard from Dr. James, who told us that up to half of what we spend on healthcare is unnecessary.

At our third hearing later in July, we looked at administrative tasks imposed by the Federal Government and how those burdens lead to doctors spending more time on paperwork, less time on treating patients, and all of this also increases costs.

In September, we looked at why, when you check reviews and prices before buying everything from a coffeemaker to a car, the cost or the price of your healthcare has remained hidden in a black box.

This is something even the Federal Government's top healthcare official knows personally. Health and Human Services Secretary Alex Azar recently told a story of how his doctor ordered him to have a routine echo cardio stress test. He was sent down the street and admitted to the hospital, where, after a considerable effort on his part, he learned the test would cost him $3,500. After using a website that compiled typical prices for medical care, Secretary Azar learned the same test would have cost just $550 in a doctor's office. Secretary Azar said consumers are so in the dark, they often feel ''powerless.''

In an age where you can compare different prices and check a dozen reviews when you are buying a barbecue grill, you should be able to more easily understand what you are paying for healthcare.

Last month, at our fifth hearing, we heard about steps the private sector is taking to disrupt the healthcare system and what kinds of Federal barriers are preventing private companies from lowering costs. As we held our five hearings, two conclusions became clear.

The first is that we spend more on healthcare than does any other country, but we don't spend it well.

Again, Dr. James told us that 30 percent—maybe as much as 50 percent—of all of the money we spend on healthcare is unnecessary. That is really astonishing. It echoes what Dr. Ashish Jha said, who was a witness from our first hearing and is the Director of the Harvard Global Health Institute. He said this:

> The popular belief has been that the reason we spend so much more on healthcare than other countries is that we just use too much healthcare. Well, it turns out when you look at the data . . . we are not using more healthcare. Why is it we are spending twice as much? There are two reasons. One is administrative complexity, [and second], every time we use healthcare in America, we pay a lot more than any other country in the world.''

That was Dr. Ashish from the Harvard Global Health Institute.

Second, while it would be convenient to have a moonshot to reduce healthcare costs, this will require people other than the Federal Government.

First, as the largest purchasers of health insurance, employers are really leading the way in the effort to reduce costs. For example, let's take International Paper, which is based in Memphis. It uses a service called Best Doctors. Employees can use it for second opinions on healthcare. Best Doctors reviews an employee's records, and then it either reaffirms the treatment that has been recommended by a doctor or it recommends a different course, such as physical therapy. The use of this voluntary program saved International Paper over $500,000 in 2017 by preventing unnecessary treatments.

Another way employers reduce healthcare costs is through wellness programs, which encourage employees to lead healthier lives. There is probably no greater consensus in healthcare than that wellness—lifestyle changes, such as eating healthier and stopping smoking—can prevent serious illness and reduce healthcare costs. It is hard to think of a better way to make a bigger impact on the health of millions of Americans than to connect the consensus about wellness and reducing health costs to the health insurance that 181 million people get on the job. About 60 percent of insured Americans get our health insurance on the job.

Second, States are taking an active role in the cost of healthcare.

In 2017, the State of Maine required health insurers to split the savings with a patient if the patient shops around and chooses a doctor who costs less than the average price the insurer pays. In Oregon, the State compiles data on insured residents and uses this information to run a tool that allows patients to compare the costs of procedures at different hospitals.

Third, private companies are creating innovative tools to reduce healthcare costs. For example, Healthcare Bluebook, a Nashville company and a witness at one of our hearings, provides a tool that helps patients find the best prices for the highest quality care in their areas by using their employer-sponsored insurance, which, as I said, 60 percent of insured Americans have. This is useful in lowering costs because, for example, the amount a patient pays for cataract surgery in Memphis can range from as little as $2,000 to more than $8,000.

Fourth, hospitals, doctors, and other healthcare providers have the potential to make a large impact on the cost of healthcare.

On a smaller scale, one of our witnesses, Dr. Gross from Florida, runs a practice under what is called the direct primary care model. Dr. Gross charges a flat membership rate of $60, in cash, per patient for adults under the age of 65, $25 for one child, and $10 for each additional child. His practice does not bill anything to an insurance company for direct primary care members—not to ObamaCare, not to Medicaid, not to Medicare. In return for this membership fee, members receive an annual wellness exam, 25 office visits per year, including same-day appointments, and some in-office testing and chronic disease management without having to pay anything additional out of pocket. This gives patients access to a defined level of healthcare at a predictable price, which ranges from about $1,000 to $1,200 a year.

On a larger scale, HCA Healthcare, which also testified—it has 178 hospitals and 119 freestanding surgery centers that are located in the United States and the United Kingdom—is implementing new techniques to reduce the spread of MRSA, which is a drug-resistant bacterial infection that occurs in intensive care units.

These new techniques have reduced cases of MRSA by 37 percent in HCA facilities and have been so effective that the World Health Organization and the Centers for Disease Control and Prevention have added them to best practices. According to HCA, this reduction in MRSA infections saves $170,000 for every 1,000 patients. These savings are shared among the hospitals, insurers, and patients.

Finally, information needs to be easily available so that patients, consumers, can find out the prices of their care and take an active role in choosing their healthcare and in planning for medical expenses whenever they can.

There is also a role for the Federal Government to play. The Federal Government spent, as I said earlier, $1.1 trillion on Medicare, Medicaid, and other healthcare programs in 2017. About one-third of all healthcare spending in America is by the Federal Government, so how we spend those Federal dollars will obviously make a big difference to the healthcare system. There may also be things Washington can do or is doing to increase healthcare costs or to prevent private companies from taking steps to lower those healthcare costs.

I want to find out what concrete, specific steps the Federal Government can take to reduce unnecessary healthcare spending or to at least stop making the problem worse. For example, after our committee heard about gag clauses, which prohibit pharmacists from telling patients their prescriptions would be cheaper if they paid in cash instead of through their insurance, Congress was able to act and ban those gag clauses earlier this year. In August, the CMS began to require hospitals to post online the amounts they charge for services and to keep that information up to date. These are the types of specific recommendations I am looking for.

In working with experts, I have had some success in asking them for recommendations in priority order and then turning those recommendations into legislation.

In 2005, I was a member of the Budget Committee, and I had become concerned about the rapid increase in the

Federal debt and how it was squeezing out some of the essential programs that make our country competitive. So I stopped by a meeting of the National Academy of Sciences on American competitiveness, and I said to them: Most ideas fail in Washington, DC, for there being the lack of an idea. If you, the academy, will give Congress 10 specific ideas in priority order to improve American competitiveness, I believe Congress will enact those ideas.''

The academy immediately got busy and recruited Norm Augustine and then put together a task force of American leaders, called the Committee on Prospering in the Global Economy of the 21st Century. Under Norm's leadership, they produced a National Academies report entitled ''Rising Above the Gathering Storm.'' They came up with 20 ideas, not just 10, and they were specific, such as doubling the funding for basic science research and creating an energy agency to be modeled after the Department of Defense's highly successful DARPA agency, which would invest in the high-potential, high-impact energy technologies—what we now call ARPA-E.

Congress used most of those ideas and put together a bill that we called America COMPETES. We passed it in 2007 and reauthorized it in 2010. It was introduced by the majority and minority leaders and had a large number of Republican and Democratic sponsors.

That is an example of what can happen when experts give us specific recommendations toward an important public goal and give them to us in a way that we can actually implement them.

That is what I am looking for in the letter that I am sending to experts today at the American Enterprise Institute and at the Brookings Institution—specific recommendations, preferably in priority order, about what Congress and the President can do to reduce the staggering healthcare costs, which is a problem in America. Our witnesses from the National Academy of Sciences and all across the board tell us that nearly half of everything we spend on healthcare is unnecessary.

I also want input from other leading policy experts, including economists, doctors, nurses, patients, hospital administrators, State regulators, legislators, governors, employers, insurers, and healthcare innovators. I am asking, in writing, for as many specific legislative, regulatory, or sub-regulatory solutions as possible by March 1, 2019.

I am especially interested in policies that bring to the healthcare system the discipline and lower cost benefits of a real, functioning market. One way to do that is to remove the barriers that discourage innovators from coming up with new ways to reduce healthcare costs. A second way is to make it easier for the consumers of healthcare to know the true price of what they are buying.

I welcome suggestions of how those policy ideas could be implemented—what law to amend, what regulation to change—and any potential downsides to the policy recommendations. I will share the recommendations with Senator PATTY MURRAY, who is the ranking Democratic member of the Senate's HELP Committee, and with all of the members of our committee. I will share the recommendations with Senator GRASSLEY and Senator WYDEN, who are expected to be the chairman and ranking member of the Finance Committee. Our HELP Committee and the Finance Committee have shared jurisdiction over healthcare costs. It sometimes gets in the way of solutions, but there is no reason it should. We should all be able to work together in a bipartisan way to address this startling phenomenon that the experts tell us is true, which is that we are spending nearly half the money—wasting it unnecessarily on healthcare. Now we need the experts to tell us exactly what to do about it.

The Federal Government is not going to lower the cost of healthcare overnight, but I believe there are steps we can take to make a real difference to American families. It might be two or three big steps, or it might be a dozen smaller steps, but we shouldn't let this opportunity to make progress pass us by.

I ask unanimous consent that the letter I have written and am mailing today to experts at the American Enterprise Institute and the Brookings Institution, as well as to other leading healthcare experts, be printed in the RECORD following my remarks.

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

DECEMBER 11, 2018.

JAMES C. CAPRETTA,
Resident Fellow and Milton Friedman Chair, American Enterprise Institute, Washington, DC.

PAUL B. GINSBURG, PH.D.,
Director, Center for Health Policy, Brookings, Washington, DC.

DEAR MR. CAPRETTA AND DR. GINSBURG: I am writing to ask for your specific recommendations to help address America's rising health care costs. The Senate Committee on Health, Education, Labor and Pensions (HELP) I chair has held five hearings on the cost of health care and heard from Americans from across the country—from Alaska to Tennessee—that health care costs are a growing burden on taxpayers, employers, and family budgets.

At a hearing in July, we heard a startling estimate from our witness, Dr. Brent James, a member of the National Academy of Medicine, who said that 30 percent, and probably over 50 percent, of all health care spending in America is unnecessary. That means that American taxpayers, patients, and businesses are wasting as much as $1.8 trillion a year. A number of witnesses corroborated Dr. James' estimate, pointing to causes such as excessive and duplicative federal reporting requirements on doctors and hospitals and a lack of accessible information on health care costs and quality.

I am sending this request to additional experts including economists, doctors, nurses, patients, hospital administrators, state lawmakers, governors, employers, insurers, and health care innovators, on what steps the next Congress should take to address America's rising health care costs as well as any steps we can recommend that the Trump Administration or state governments should take.

For the last eight years, Republicans and Democrats have been locked in a stalemate over the cost of insurance in the individual health insurance market, where six percent of all Americans with health care purchase their insurance. This is an important part of the discussion, but it puts the spotlight in the wrong place. The hard truth is that we will never get the cost of health insurance down until we get the cost of health care down.

This is why the HELP Committee has been holding hearings on how to reduce administrative burdens; how to reduce what we spend on unnecessary health care tests, services, procedures, and prescription drugs; how to reduce the prices of health care goods and services; how to make available more information on the cost and quality of care; and how the private and public sectors have been able to lower health care costs.

I am especially interested in trying to bring to the health care system the discipline and cost saving benefits of a real market. Too many barriers to innovation drive up costs. And most Americans have no idea of the true price of the health care services they buy—which also drives up costs.

I request that you provide written responses to the below questions by email to LowerHealthCareCosts@help.senate.gov by March 1, 2019:

1. What specific steps can Congress take to lower health care costs, incentivize care that improves the health and outcomes of patients, and increase the ability for patients to access information about their care to make informed decisions?

2. What does Congress or the administration need to do to implement those steps? Operationally, how would these recommendations work?

3. Once implemented, what are the potential shortcomings of those steps, and why are they worthy of consideration despite the shortcomings?

Thank you for your consideration and attention to this request.

Sincerely,

LAMAR ALEXANDER,
Chairman.

Mr. ALEXANDER. I yield the floor.

I suggest the absence of a quorum.

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

The senior assistant legislative clerk proceeded to call the roll.

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

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

BORDER SECURITY

Mrs. CAPITO. Madam President, we are faced today with an escalating crisis on our southwest border. We all know it. We see news of it every day, and it is very real.

As the chairman of the Appropriations Committee's Subcommittee on Homeland Security, I would like to present some facts to the Senate that make the case for increased investment in our border security.

In the fiscal year 2018, Border Patrol apprehensions at the southwest border were up more than 30 percent compared with fiscal year 2017. In real numbers, over 396,000 people were apprehended.

It is getting worse because, if you look at October of 2018 compared to October of 2017, apprehensions were up 88 percent. The numbers are going up.

The facts I have laid out don't tell the entire story. Border Patrol estimates that it could be catching as little as half of the traffic that is illegally crossing our southwest border between the ports of entry, so we really don't know who we are catching, and we don't know what they are carrying.

Border Patrol apprehensions of gang members is up 50 percent from fiscal year 2017 to fiscal year 2018. Mexico is a primary source for narcotics entering the United States. This is extremely important to me as a representative from the State of West Virginia. Fentanyl seizures by Border Patrol were up 115 percent over the past year, from 2017 to 2018.

We know that a significant portion of opioids enter our country through ports of entry, but we cannot ignore the fact that we are seeing opioid smuggling between the ports of entry increase at alarming rates as well.

Similarly, methamphetamine seizures by Border Patrol have increased 75 percent since the year 2015. In more populated areas along the border, aliens and smugglers are crossing the border unimpeded and quickly vanishing into our neighborhoods, into our commercial areas, and onto highways, headed to places like Mississippi and West Virginia.

A single load of fentanyl, walked across our land border in an unassuming backpack, could threaten the lives of several thousand Americans. Failure to better secure our border will have consequences for all American communities.

I am very sad to say that my home State is an acutely affected area. In the year 2017, drug overdoses were responsible for more deaths per capita in West Virginia than in any other State. Listen to this. This is so sad. Overdoses tragically took the life of 1 out of every 1,700 West Virginians and 1 out of 46 Americans in this country. We saw a 500-percent increase in meth overdoses in West Virginia from the years 2013 to 2017. What I have learned about this is that we have gone from prescription drugs to heroin, to heroin laced with fentanyl, and now it is synthetic methamphetamines that are the threat. This is occurring while we are seeing an uptick in meth that is mass produced in places like Mexico, trafficked across our border, and then distributed across the United States. Even more troubling, these types of meth are also being laced with the synthetic and dangerous opioid, fentanyl.

In this current debate, it is easy to forget that just over a decade ago, on a bipartisan basis, Congress—and I was over in the House of Representatives at the time—was making significant investments in our border security infrastructure. What we have seen from these past investments is that physical barriers actually work at the border. The statistics show that.

In the 1990s and 2000s, we built physical barriers in four sectors: the San Diego sector, the El Paso sector, the Tucson sector, and the Yuma sector. In each of these places, the number of apprehensions dropped by more than 90 percent after the infrastructure was installed. In these areas, investment in border security has enhanced the safety and the security on both sides of the border.

Neighborhoods that were once overrun with illegal activity are vibrant. Commercial areas that were once considered dangerous and unprofitable are now flourishing with economic development. Nature preserves that were once trashed and trampled are again full of our native plants and animals.

The cartels on the other side of the border profit in places where we haven't invested. Criminals aren't going to stop smuggling humans and narcotics into the United States because we have invested in certain key places; they have simply changed their routes and shifted their tactics to areas where we haven't yet built infrastructure.

If we fail to better secure our border, we are inviting vulnerable migrant populations, many of whom may be fleeing danger in their own home communities, to subject themselves to dangerous journeys through rugged terrain. They are often doing so under the thumb of cartels who profit from the illegal human trafficking, just as they profit from drug trafficking.

We need to secure our borders and encourage these migrants to instead seek entry legally at the designated ports of entry.

This past summer, I traveled for several days to the southwest border, both in California and in Texas. I witnessed the needs that we have there firsthand. I saw the open pathways across the border and into our communities. I saw the gaps in our border security. I also saw communities that have become safer because we have provided border security. I didn't just see those things; I heard from the men and women who patrol our border each and every day. It is a tough job. It is a tough job. They expressed the need for and the value of the investments I am talking about here today.

While the need for additional investment in border infrastructure may be obvious to some, Congress has recognized that we need to be strategic in these investments. It was said on the Senate floor last week that there is no plan for these investments. I am here to tell you that is not the actual, true story.

In fact, the bipartisan fiscal year 2017 appropriations bill required Customs and Border Protection to provide us with a comprehensive border security plan, an improvement plan, to ensure that we get it right. This plan was developed sector by sector by agents in the field, and it was weighted by illegal activities that are occurring in those sectors. It was written from the bottom up by career law enforcement professionals who walk the line every day, sometimes on boats on the Rio Grande—we did that too—and know where new infrastructure is needed most.

The plan was delivered in January of 2018 and provided us with a 10-year roadmap for border security investment based on operational requirements. Here is what we learned from this plan.

As traffic slowed in San Diego, in Arizona, and in El Paso, we have seen it shift to South Texas, to the Rio Grande Valley sector. This sector covers just 17 percent of the mileage of the entire border, but it now sees 40 percent of the illegal border traffic. This sector also accounts for an outsized number of narcotic seizures and a significant portion of the assaults on our Border Patrol agents.

Through the fiscal year 2018 appropriations bill enacted in March, Congress provided a downpayment of nearly $1.4 billion toward this plan, this improvement plan.

Despite claims on the Senate floor last week to the contrary, Customs and Border Protection is executing this funding at an astounding rate. About one-third of it is already under contract. Another third will be under contract in the next several weeks, and the entirety of this funding will be under contract within a year of enactment of this legislation. They are spending it where it is needed most and as fast as we can get it to them.

In June, the Appropriations Committee, led by my subcommittee, produced a bill that recommended border security funding in line with this plan. Specifically, the bill recommended significant funding for new physical barriers along the southwest border. This is a very good bill, but over the summer and over the fall, this crisis on the southwest border has escalated.

I believe we in Congress must demonstrate that we are flexible enough to respond when the situation calls for it. The statistics I cited certainly make a compelling case.

Providing additional resources in fiscal year 2019 and fiscal year 2020 for border security infrastructure would be consistent with the border security improvement plan when viewed through the lens of an escalating crisis. This funding would go straight to the places in South Texas where we are seeing the most illegal traffic.

It is important to note that providing an appropriate level of funding is possible without exceeding any of our budget caps and without shortchanging any of our other very important programs, as long as we get serious about finding a bipartisan way forward.

I will take a time out here to recognize that Senator SCHUMER and rising Speaker PELOSI are going to be meeting with the President on this very issue today, so I urge them to reach a bipartisan way forward.

I urge my colleagues here in the Senate to take a long, hard look at the undisputable facts, which demonstrate that the crisis on the border is escalating. Our law enforcement personnel have provided us with a plan to work toward improving and solving that problem, so let's work together and get this done.

I yield back my time.

The PRESIDING OFFICER. The Senator from Washington.

NOMINATION OF JONATHAN A. KOBES

Mrs. MURRAY. Madam President, I come to the floor today to oppose Jonathan Kobes' nomination to serve on the 8th Circuit Court of Appeals. People across the country know how important it is that we fight back against extreme and extremely unqualified judicial nominees.

Earlier this year, during Judge Kavanaugh's confirmation, we saw just how far President Trump and Senate Republicans are willing to go to jam through extreme judges who will work to strip away women's rights.

But that wasn't all we saw. We saw millions of women and men across the country inspired to stand up and fight back against his nomination. We saw people speak out and share their own personal stories about what was at stake, about sexual assault, and how important it is that we believe survivors, and about the right to safe legal abortions, what it means for women and their families, and about what kind of country we want to live in.

We saw, without question, that people across the country want us to stop President Trump from swinging our courts far right by packing them with ideological judges—judges like Mr. Kobes, who will continue the Trump-Pence agenda of rolling back women's rights and access to healthcare.

Making sure families know exactly what Mr. Kobes would mean for women if he is seated is what I am here to do today. It means weaker rights and less access to healthcare.

He is like many of President Trump's nominees before him. Mr. Kobes lacks almost any real experience to qualify him for a seat on the Eighth Circuit Court. He has little trial experience, little appellate experience, and no record of legal scholarship to speak of.

I am not the only one concerned by that. The American Bar Association has rated him unqualified. That makes Mr. Kobes the sixth judicial nominee from President Trump who is opposed by his professional colleagues.

But the thin record he does have is disqualifying because it shows he will put extreme rightwing ideology ahead of women and science. Mr. Kobes is an outspoken advocate for fake women's healthcare centers, sometimes called crisis pregnancy centers, that seek out women looking for information about their healthcare needs and reproductive rights and then use misleading—even blatantly false—propaganda to scare and pressure them. Mr. Kobes even went out of his way to represent some of these fake clinics free of charge.

He voluntarily defended a law requiring providers to give a lecture full of ideological propaganda and fearmongering to women seeking safe, legal abortions. The required lecture in this case actually went so far as to demand that providers lie to women and claim abortion increases their risk of suicide. It does not.

Think about that. He argued for a law that directly interfered with the relationship between a patient and her healthcare provider—a law that said women making their own decisions about their own bodies and seeking healthcare, which is their constitutional right, should be lied to, should be frightened out of a decision with fake information, including fake information about suicide. That is utterly wrong and disqualifying for any judicial nominee.

Mr. Kobes hasn't merely represented these fake clinics. He served on the board of an organization that aimed to deceive and frighten women out of getting abortions. It is clear he wasn't chosen for his bona fides in the legal field. He doesn't have them.

Women and men across the country are paying attention. They know what is at stake. Hours before the final vote on Kavanaugh, I came here to speak about how angry I was when the Senate failed Anita Hill in 1991 and confirmed Justice Thomas, how I decided to run for the Senate after that so I could fight to change things, and how I hoped everyone who was angry about Judge Kavanaugh would stay angry and keep fighting for change. I also promised right here that whatever happened, I was going to get up the next day and keep fighting, too, and I meant it.

I am going to keep standing up, speaking out, and making clear just how harmful the President's ideological nominees are.

I strongly oppose Mr. Kobes' nomination. I hope all of our colleagues will do the same.

Thank you.

I yield the floor.

The PRESIDING OFFICER (Mr. KYL). The question is, Will the Senate advise and consent to the Muzinich nomination?

Mrs. CAPITO. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

Mr. CORNYN. The following Senator is necessarily absent: the Senator from North Carolina (Mr. TILLIS).

The result was announced—yeas 55, nays 44, as follows:

[Rollcall Vote No. 257 Ex.]

YEAS—55

Alexander, Barrasso, Blumenthal, Blunt, Boozman, Burr, Capito, Cassidy, Collins, Coons, Corker, Cornyn, Cotton, Crapo, Cruz, Daines, Enzi, Ernst, Fischer, Flake, Gardner, Graham, Grassley, Hatch, Heller, Hoeven, Hyde-Smith, Inhofe, Isakson, Johnson, Jones, Kennedy, King, Kyl, Lankford, Lee, McConnell, Moran, Murkowski, Nelson, Paul, Perdue, Portman, Risch, Roberts, Rounds, Rubio, Sasse, Scott, Shelby, Sullivan, Thune, Toomey, Wicker, Young

NAYS—44

Baldwin, Bennet, Booker, Brown, Cantwell, Cardin, Carper, Casey, Cortez Masto, Donnelly, Duckworth, Durbin, Feinstein, Gillibrand, Harris, Hassan, Heinrich, Heitkamp, Hirono, Kaine, Klobuchar, Leahy, Manchin, Markey, McCaskill, Menendez, Merkley, Murphy, Murray, Peters, Reed, Sanders, Schatz, Schumer, Shaheen, Smith, Stabenow, Tester, Udall, Van Hollen, Warner, Warren, Whitehouse, Wyden

NOT VOTING—1

Tillis

The nomination was confirmed.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BLUNT. Mr. President, I ask unanimous consent that the motion to reconsider be considered made and laid on the table and the President be immediately notified of the Senate's action.

LEGISLATIVE SESSION

MORNING BUSINESS

Mr. BLUNT. I further ask that the Senate proceed to legislative session for a period of morning business, with Senators permitted to speak for up to 10 minutes each; further, that at 2:15 the Senate vote on the Kobes nomination as under the previous order; finally, if the nomination is confirmed, that the motion to reconsider be considered made and laid on the table and the President be immediately notified of the Senate's action.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

EXCELLENCE IN MENTAL HEALTH ACT

Mr. BLUNT. Mr. President, I know that we have a number of things scheduled here, including some farewell speeches from some of our colleagues. I was scheduled to speak, and I do want to speak, and I will try not to take too much advantage of the time.

I wanted to speak today and this week about the importance of treating mental health and the importance of