provided to kidney dialysis patients. They also provide positive composite rate updates for 2 years until the bundled payment system is created.

All three bills include Medicare reimbursement for six kidney disease education sessions.

All versions of the Medicare legislation also include an expansion of telehealth services to skilled nursing facilities, hospital-based renal dialysis, and mental health centers.

So as one can see, we agree on most all the issues. Unfortunately, there is one issue where we do not agree, and it is standing in the way of getting this legislation signed into law.

H.R. 6331, the House Medicare bill, and the Baucus Medicare bill, include provisions that would reform the Medicare Advantage Program in a way that is unacceptable to both the White House and many of us who support the Medicare Advantage Program and I believe 90 percent of the people who do support that program.

In 2003, I sat through hours of negotiations with administration officials, House Members, and Senate colleagues for days, weeks, and months, including Finance Committee Chairman BAUCUS, to create the Medicare Advantage Program to the Medicare Modernization Act of 2003. Let me remind my colleagues, before 2003, the Medicare Advantage Program, then known as Medicare+Choice, was not working very well, especially in rural parts of our country because the Medicare payments were too low. The Medicare+Choice plans serving Utah simply left because they were in the red. They were not making money and, as a result, Utah Medicare beneficiaries could only be covered by traditional Medicare.

Through the MMA, we finally figured out how to provide choice to Medicare beneficiaries in both rural and urban areas. Medicare beneficiaries in Utah now have a choice in Medicare coverage they did not have before the MMA was implemented.

The biggest difference between the bill before us today and the Grassley Medicare bill is the House Medicare bill, if signed into law, will no longer allow private fee-for-service plans to deem. You are probably asking: What on Earth is deeming? It is quite simple.

Deeming allows beneficiaries who have opted for private fee-for-service plans the ability to see any Medicare provider because these plans do not have to establish networks.

Private fee-for-service plans have provide coverage options to Medicare beneficiaries living in rural areas who previously did not have choice. In other words, the ability to deem has been especially important in rural areas, where it is difficult for network-based plans to persuade providers to contract with them and for employer groups that provide coverage for retirees living in areas across the country.

The elimination of deeming could be the elimination of health care coverage choices for beneficiaries living in rural areas.

It could also cause certain retirees to lose their health care coverage because employer health plans that provide coverage in all 50 States will cease to exist because they cannot establish networks.

My friends who support this bill will argue they are not cutting the Medicare Advantage Program by eliminating deeming. They also will try to say that the elimination of deeming will not have an impact on health care choices offered to beneficiaries living in rural areas.

I have already been told by one employer in Utah that this provision will force them to stop offering health care coverage to almost 12,000 retirees—12,000 retirees. I am worried it could hurt coverage for beneficiaries in rural areas as well. Quite honestly, we do not know the full impact of this specific policy.

Therefore, I simply cannot support a provision that eliminates deeming for private fee-for-service plans, and that is one of the reasons I am going to vote against cloture.

We must vote against cloture in order to ensure we can begin work on a bipartisan bill that will be signed by the President. We do not need to be wasting our time going back and forth on bills that do not have a chance of becoming law.

Trust me, this bill will not be signed into law because, while the take-it-or-leave-it attitude may work over in the House, it does not work in the Senate.

I urge my colleagues to vote against cloture so we may begin work on a bipartisan bill that will continue to protect choice of coverage for all beneficiaries—and I think that work would take all of 10 minutes—including those living in urban and rural areas and those who are covered through an employer retirement plan.

This motion must be defeated so we can prove to Medicare beneficiaries, Medicare providers, and our House colleagues that bipartisanship is alive and well in the Senate and that we are willing to keep working on this bill until we get it right.

The PRESIDING OFFICER (Mr. SANDERS). The majority leader.

UNANIMOUS-CONSENT AGREEMENT—H.R. 6331 AND H.R. 2642

Mr. REID. Mr. President, I ask unanimous consent, notwithstanding rule XXII, and the pendency of a motion, that a motion to proceed to Calendar No. 836, H.R. 6331, the Medicare Improvements for Patients and Providers Act, be considered made by virtue of this agreement and there be 60 minutes of debate on the motion, with the time equally divided and controlled between the leaders or their designees; that upon the use or yielding back of time, the Senate proceed to vote on a motion to invoke cloture on the motion to proceed, with the mandatory quorum waived; that if cloture is invoked on the motion to proceed, then all postcloture time be yielded back, the motion to proceed be agreed to, and the Senate proceed to the consideration of the bill; that the bill be read a third time, passed, and the motion to reconsider be laid upon the table, without further intervening action or debate; that if cloture is not invoked, then the motion to proceed be withdrawn and the bill returned to the calendar; that upon the disposition of H.R. 6331, the Senate then consider the message from the House with respect to H.R. 2642, the Supplemental Appropriations Act; that by virtue of this consent being agreed to, the motion to concur in the House amendments to the Senate amendment to the House amendment to the Senate amendment to the bill be considered made; that Senator COBURN be recognized to raise a point of order and that there be 15 minutes of debate, with 5 minutes each for COBURN and the majority leader and the Republican leader, or their designees; that upon the use of that time, a motion to waive the Budget Act be considered made and the Senate then vote on the motion to waive; that if the waiver is successful, the Senate proceed to vote on the motion to concur; that upon disposition of the motion to concur, the motion to reconsider be laid upon the table, en bloc, with no further motions in order; provided further, that if the motion to waive fails, then this agreement be null and void.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Republican leader.

Mr. MCCONNELL. I, obviously, am not going to. I ask my good friend, the majority leader, if he thinks we need 60 minutes of debate. Is there some chance time will be yielded back?

Mr. REID. We would be happy to limit that—the supplemental appropriations bill we are talking about?

Mr. MCCONNELL. No.

Mr. REID. On Medicare. I say to my friend, I think Senator HATCH wants to finish his statement, Senator DURBIN is here. I think we should do the 60 minutes.

The PRESIDING OFFICER. The majority leader.

Mr. REID. There was no objection to the request; is that right?

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

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT—MOTION TO PROCEED

CLOTURE MOTION

Mr. REID. Mr. President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows: