United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

Vol. 155 WASHINGTON, TUESDAY, DECEMBER 1, 2009 No. 176

Senate

The Senate met at 10 a.m. and was called to order by the Honorable ROLAND W. BURRIS, a Senator from the State of Illinois.

PRAYER

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

Let us pray.

Our Father God, author of liberty, as our governmental leaders face grave questions and perplexing problems so vitally affecting national welfare and world concord, we bow in reverence in Your presence. We acknowledge that it is because of You that we live and move and have our being.

Strengthen the leaders of our executive, judicial, and legislative branches to make their utmost contribution to the healing of the tangled tragedy of our troubled world. Through the lips that speak in this forum of freedom, Lord, speak to our Nation and world so that Your will may be accomplished on Earth. Heal the divisions which shorten the arm of our national might in this decisive season. Help our lawmakers to be patient and considerate one with another, as You give them reverence for truth and a passion for justice.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable ROLAND W. BURRIS 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 1, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable ROLAND W. BURRIS, a Senator from the State of Illinois, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. BURRIS 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 the remarks of the two leaders, the Senate will resume consideration of H.R. 3590, the health care reform legislation. That will be until 11:30 a.m., for debate only. The Republicans will control the first 30 minutes, the majority will control the next 30 minutes. Any remaining time will be equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each.

At 11:30 a.m., the Senate will turn to executive session to debate the nomination of Jacqueline Nguyen to be a U.S. District Judge for the Central District of California. The vote on confirmation of that nomination will occur at 12 noon today. That will be the first vote today.

The Senate will recess from 12:30 to 2:15 p.m., to allow for our weekly caucus luncheons. Following the recess, the Senate will resume consideration of the health care reform legislation. Additional votes are expected this afternoon in relation to the health care legislation.

HEALTH CARE REFORM

Mr. REID. Mr. President, here are two truths about the historic health care reform bill that is now before this body. First, it will save money, it will save lives, and it will save Medicare. Again, the legislation before this body will save lives, money, and Medicare.

While this is a pretty good start toward that, the second fact is, there is always room for improvement for this bill. Of course, that is what the legislative process is all about. Senator BARBARA MIKULSKI of Maryland has offered an amendment that does both. Her proposal would improve this bill by making sure women get, at no cost, the preventive screenings they need to stay healthy. These are important screenings that can catch potential problems as early as possible and that will save lives and save money.

Health care premiums rise higher and higher every year. The insurance industry this year has already raised insurance rates an average of 10 percent—an average. Of course, this is far faster than incomes in this country, and that is an understatement. As this happens, more and more women are simply skipping the important preventive care they need. Why? They are skipping screenings for cervical cancer, they are skipping screenings for breast cancer, they are skipping screenings for pregnancy. They are even skipping annual checkups and doctor visits that could flag serious problems, such as postpartum depression and domestic violence.

Why is this happening? Do women simply care less about their well-being? Of course not. Are diseases on the decline? Quite to the contrary. The only reason women are putting off going to the doctor is because, in our broken health care system, it simply costs too much to stay healthy.

Senator MIKULSKI's amendment also makes clear that the decision of whether and when to get a mammogram

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Printed on recycled paper.

should be made by a patient and a doctor. It shouldn't be made by an insurance company, by Members of Congress or by someone you have never met. No matter what independent task forces recommend and no matter what some Republican Senators falsely claim, this legislation—the one before this body—offers free preventive services to millions of women who are being discriminated against by their insurance companies, and this amendment before this body makes that absolutely clear.

Senator MIKULSKI has long been someone who has been a leader and has looked out for women's health. Years ago, she worked with me on a problem women have; 90 percent of the people who have a disease called interstitial cystitis are women. I discovered that when three women came to visit me in Las Vegas. It was a disease that was ignored. People thought it was psychosomatic. Working with Senator MIKULSKI, we had the National Institutes of Health set up a protocol. Now 40 percent of those people, who previously were thought to be psychosomatic and who suffered with symptoms they described as shoving slivers of glass up and down their bladder, are symptom free—not 100 percent but 40 percent. It is easier to diagnose now.

Senator MIKULSKI has also worked hard to have the National Institutes of Health set up a division for women's health problems. So she is a leader in this area, has been for a long time, and with this amendment she does it once again.

I am sorry to see Republicans deliberately confuse the facts about women's health, particularly as they relate to mammograms. It shows how desperate some of them are to distract the American people from the real debate and from the fact they have no vision for fixing our health care system, which is so broken.

I am even more sorry to say it is part of a larger trend. In recent days, they have been distorting the data from the Congressional Budget Office, an independent agency Republicans in the past have praised. What are they complaining about now, the Republicans? They are complaining about two of this Nation's top priorities: reforming our health care insurance system and helping our economy recover.

First, on health care. The Congressional Budget Office said yesterday the majority of American families who buy insurance in the new marketplace we will create—what we call health insurance exchanges—will see their premiums go down. They will go down by as much as 60 percent. Out of 100 percent of the American people, 93 percent will have a drop in their insurance premiums with this legislation—93 percent.

CBO's experts aren't the first to recognize these benefits. Massachusetts Institute of Technology's Jonathan Gruber, who is one of the most respected economists in the world, said in today's Washington Post:

> Here's a bill that reduces the deficit, covers 30 million people and has the promise of lowering premiums in the long run.

Pretty good statement. That means millions of Americans who today cannot afford coverage or whose medical bills drive them to financial ruin. Remember what I said yesterday as this debate began. Last year, 750,000 people in America filed for bankruptcy. Almost 70 percent of the bankruptcy filings were because of health care costs. But of those people who filed for bankruptcy because of health care costs, 62 percent of them had health insurance. Does that speak about a system that is in trouble? Of course it does.

So I repeat: This bill will mean millions of Americans who today cannot afford coverage or whose medical bills drive them to financial ruin will be able to afford to stay healthy. It means, if we don't reform health care, millions more will find themselves in bankruptcy, bad health or worse.

Second, on economic recovery. The Congressional Budget Office said yesterday the extraordinary steps we took to bring our economy back from the brink have created and saved hundreds of thousands of jobs. I will direct my comments to the American people but also to the brave Republicans who joined with us to make this possible—Senators SNOWE and COLLINS. I want them to know that what they did helped us get that legislation passed and, according to the Congressional Budget Office, saved hundreds of thousands of jobs. The CBO said yesterday the extraordinary steps we took to bring our economy back from the brink have created or saved hundreds of thousands of jobs. Its estimate reaches as high as 1.6 million jobs, each one a direct result of our economic recovery plan. Pretty good. The same report also said our country's gross domestic product has gone up by as much as 3.2 percentage points higher than it would have if we hadn't acted.

Let us not do what our colleagues on the other side of the aisle are doing—betting on failure. This country is coming out of a hole that was dug by this administration for some 8 years. The facts are that what we did on a bipartisan basis in January and February has brought this country out of an economic hole. We still have a ways to go, no question about it. But we created 1.6 million jobs and increased the gross national product by as much as 3.2 percentage points. Pretty good. These facts tell us the same thing: Not acting is not an option.

Some of my Republican colleagues prefer to close their eyes and ears to this reality. They prefer to play politics than to do what is right and what is necessary. They are content to say no, instead of offering constructive alternatives and a way to lead our country and our constituents back to health.

At the beginning of this second day of debate, I say: Come along and work with us to improve this legislation. Try to improve it the way Senator MIKULSKI looked at it and said: This legislation can be improved. We want to work with the minority. We want to have legislation that is bipartisan. We don't want to do this alone. We need the Republicans' help, and I hope they will join with us. It would certainly look better. Let's stop berating this legislation before this body. If they do not like it, try to do something to make it better.

As we know, this legislation saves lives, it saves money, it saves Medicare, and it brings down insurance premiums. That is a pretty good deal. And it brings down the debt. It saves $130 billion over the next 10 years and, after that, $650 billion. Not bad. So the numbers they keep talking about are out of—I don't know where they come from. We, as a body, have used the Congressional Budget Office for 50 years. It is bipartisan. That is the way it should be. We should start talking real numbers, not fake numbers.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, certainly in a country of 300 million people there are differences of opinion, and you will see them on full display in the Senate on this monumental 2,074-page scheme that would expand the reach of government deeper into our lives, raise taxes, increase health care premiums, and cut Medicare for seniors.

On the other side are the American people. We know, from all the surveys we have seen, the American people are opposed to this bill. They are astonished that we are trying to pass a bill that is clearly opposed by the American people in every survey that has been published.

Americans do support reform, but this isn't the reform they were asking for, and it is not the reform they were told they could expect. In fact, it is pretty clear by now that the American people were sold a bill of goods when the administration and its allies in Congress said their health care bill would lower costs and help the economy because the plan that has been produced, that is before the Senate, will not do either.

The debate is no longer about improving care by reducing costs. We are past that. This plan will raise costs on American families, and it will make an already struggling economy even worse. The only question now is how we got to a point where we are actually considering spending trillions of dollars on a brand new government entitlement at a time when more than 1 in 10 Americans is looking for a job and when our debts and deficits are well past the tipping point.

For many, the answer to that question is quite clear. We know that some here in Washington have wanted government-run health care for many years. It is hard to escape the conclusion that these same people saw the current economic crisis as their moment. Earlier in this year, some in this administration said that ''a crisis is a terrible thing to waste.'' Americans are hoping this bill is not what they meant, but they are concerned that it is.

Americans already know this bill will make our economic problems worse, not better, without even addressing the serious health care problems we already face—and they would be right. That is why they want us to start over and accomplish the real mission of lowering costs.

That is precisely what the McCain amendment would allow us to do. The McCain amendment would send this bill back for a rewrite. It would send it back to the Finance Committee with instructions to give us a new bill that does not include $½ trillion cuts to Medicare. It would send the bill back to committee; send us a new bill without $½ trillion cuts to Medicare, one that does not pay for the bill on the backs of seniors; that is, if you pass the McCain amendment.

Here is a program, the Medicare Program, that is already struggling, a program that needs help. Yet, in order to finance their vision of reform, our friends on the other side want to use Medicare as a piggy bank to create an all-new government program that is bound to have the same problems as Medicare. As written, their bill would cut nearly $½ trillion from Medicare—not to make the program stronger but to fund more government spending. In the process, millions of seniors would lose benefits. Literally millions of seniors would lose benefits.

The McCain amendment would not let that happen. The McCain amendment tells the committees: Don't cut hospitals. The McCain amendment tells the committees: Don't cut hospice. The McCain amendment tells the committees: Don't cut home health care. The McCain amendment tells the committees: Don't cut Medicare Advantage. It would allow us to focus our efforts, instead, on the prevention of waste, fraud, and abuse, which we know to be rampant in this program. It would ensure we are not cutting one government program just to create a new one. That is what a vote in favor of the McCain amendment would be, it would be a vote to preserve Medicare, not weaken it. That is the message America's seniors want to hear in this health care debate, that improving health care in America doesn't have to come at their expense.

Some may argue that they need to cut Medicare to create a new government program. That is their call. But it is not the call Americans are asking us to make. I haven't gotten a call yet from anybody in Kentucky or around the country saying: Please cut Medicare so you can start a new program for somebody else—not my first call.

The American people want us to start over from the beginning and craft a bill they can actually support, and we know they don't support this bill. All the surveys indicate that. Then we could start over and end junk lawsuits against doctors and hospitals that drive up costs, something the majority didn't find any room for in their 2074-page bill—not a word about controlling junk lawsuits against doctors and hospitals. Then we could encourage healthy choices such as prevention and wellness programs, something the majority somehow couldn't squeeze into their 2074-page bill. Then we could lower costs by letting consumers buy coverage across State lines, something the majority must have overlooked in their 2074-page bill. Then we could address the rampant waste, fraud, and abuse, something our friends didn't think was important enough to seriously address in their 2074-page bill.

The McCain amendment would allow us to vote with seniors. That is what the McCain amendment is about. It would allow the Senate to say we are not going to finance a new government program on the backs of seniors, we are not going to use Medicare as a piggy bank to fund a new government program. It would allow us to vote with the American people. Most important, it would allow us to start over and get this right.

I yield the floor.

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 home buyers 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.

Mikulski amendment No. 2791 (to amendment No. 2786), to clarify provisions relating to first dollar coverage for preventive services for women.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 11:30 will be for debate only, with the Republicans controlling the first 30 minutes and the majority controlling the next 30 minutes, with the remaining time equally divided and controlled between the two leaders or their designees and with Senators permitted to speak therein for up to 10 minutes each.

The Senator from Arizona is recognized.

Mr. KYL. Mr. President, I ask unanimous consent that during the 30 minutes controlled by the Republicans, we be allowed to engage in a colloquy.

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

Mr. KYL. Mr. President, I will begin by making some comments about the amendment Senator MCCAIN, my colleague from Arizona, has filed. This is an amendment that, as the minority leader just said, will protect America's seniors. It will disallow the Medicare cuts this bill includes.

The economist Milton Friedman famously said, ''There is no such thing as a free lunch,'' and that applies to health care as well. There is no such thing as free health care. Someone has to pay. Since this bill is a $2.5 trillion bill, the first question is, Who pays? The first answer to who pays is, it is America's seniors, because about half of the cost of the bill is allegedly paid for by cuts to Medicare.

Let me break down a little bit more specifically than the Republican leader did exactly what that means. This is about $500 billion in Medicare cuts as follows: $137.5 billion from hospitals who treat seniors; $120 billion from Medicare Advantage, which is the insurance program that provides benefits to seniors which will be cut more than in half as a result of this $120 billion reduction; $14.6 billion from nursing homes that treat seniors; $42.1 billion from home health care for seniors; and $7.7 billion from hospice care, one of the most cruel cuts of all.

Obviously, with cut this dramatic there is no way to avoid jeopardizing the care seniors now enjoy, and seniors know this. That is why they have been writing our offices and attending townhall meetings to let us know they disapprove. I quoted from two letters constituents of mine from Arizona sent asking to please not cut their Medicare Advantage Program. This has been called the crown jewel of the Medicare system, and many of them rely on Medicare Advantage for dental care or vision care or hearing assistance they have come to rely on. They are not buying the claims that somehow or other we can make $½ trillion cuts in Medicare without somehow hurting their care. They know better than that, and they are right. The care they have been promised will be compromised to pay for this new government entitlement under the bill.

Finally, many are wondering what happened to the promise that they get to keep the care they have. We all heard the President say that many times: If you like the care you have, you get to keep it. That is simply not true. There are 337,000 Arizonans who are Medicare Advantage patients. They like what they have. Yet we know, according to the Congressional Budget

Office, that the benefits they have under Medicare Advantage are going to be cut by more than half. They are saying: What happened to the policy I like? I am not going to be able to keep it if this bill passes.

This is why the McCain amendment must pass. If our Democratic colleagues are not willing to protect Medicare, then I cannot imagine how the bill could otherwise be made acceptable since it starts with the commitments that Congress and the President have made to our senior citizens.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee is recognized.

Mr. ALEXANDER. I congratulate the Senator from Arizona on his analysis of the Medicare cuts. I heard the Democratic leader talk about figures and how we have some figures and the Democrats have other figures. I agree with him. I think someone watching this must think we are on two different planets sometimes, so let me focus in on the figures.

I believe I heard my colleague say to pay for this health care bill over 10 years there would be $465 billion in the Medicare cuts. Where does that figure come from?

Mr. KYL. Mr. President, I say to my friend from Tennessee, first of all it comes from a reading of the bill. It is very clear in the bill as to how much money is taken from Medicare. The number the Senator from Tennessee just articulated is the correct number.

In addition to that, the Congressional Budget Office and the Joint Tax Committee analyzed the specific numbers. Obviously they were given the numbers in the bill, but the numbers they are using are—I just broke it down into four or five general categories. There are other divisions within that. But as I said, for notional purposes here: $137.5 billion from hospitals; $120 billion from Medicare Advantage. That number might be $118 billion; I am not precisely certain of it, but it is very close. There is $14.6 billion from nursing homes, $42.1 billion from home health, and $7.7 billion from hospice care. If any of our colleagues would like to contest these numbers, I would be happy to be corrected, but I believe those are the correct numbers.

Mr. ALEXANDER. I think the Senator from Arizona is right. The President of the United States, in his address to us about health care, and the New York Times, the Wall Street Journal—everyone who has reported on the Congressional Budget Office figures said the same thing. We are going to pay for this bill, which is $2.5 trillion over 10 years when fully implemented, by $465 billion cuts in Medicare.

What Senator MCCAIN in his amendment that we are in support of is saying is, don't cut grandma's Medicare to pay for someone else's insurance. He goes on to say, if you are going to find some savings in waste, fraud, and abuse in grandma's Medicare, spend it on grandma. The reason for that is that the Medicare trustees have said to us that there is $38 trillion in unfunded liabilities for the Medicare Program and that the program will start going bankrupt between 2015 and 2017. According to the Medicare trustees, they say, ''We need timely and effective action to address Medicare's financial challenges,'' and the proposal, if I may say to the Senator from Arizona, who is on the Finance Committee and deeply involved in what we need to do about our Nation's finances, I don't think the Medicare trustees were thinking that the timely and effective action we could take to keep Medicare from going broke was to take $465 billion out of it and spend it on some new program.

Mr. KYL. On a new program. That is exactly correct. What the Medicare trustees were saying is, if we can effect cost savings in Medicare, and surely there are some to be had there, they should go to strengthen the Medicare Program itself and not allow it to go bankrupt, rather than it being used to create a new government program.

Perhaps one of the reasons why there are different numbers from one side of the aisle to the other is that sometimes we are not talking apples to apples. We are talking apples to oranges, and perhaps both numbers are correct in their context. The Senator from Tennessee used the number $2.5 trillion when the program is fully implemented. That is a very important statement. The other side will argue it is only $1½ trillion for the first 10 years of the program. That is a correct statement. But it is $2.5 trillion for the first 10 years of total implementation of the program. What is the reason for the difference? For the first 4 years, money is being collected, but very few benefits are going out. The benefits start after year No. 4. So if we take the first 10 years of the program, we are collecting money to pay for it over the entire 10 years, but almost all of the benefits only occur during the last 6 years. Naturally, we have collected more money than we have paid out. But when we take the first 10 years of full implementation, it is as my colleague from Tennessee noted, a cost of $2.5 trillion. That is how sometimes we get somewhat different numbers.

As long as we are clear about what we are talking about, one thing is crystal clear: Whether it is $1½ trillion or $2.5 trillion, we are talking real money. Somebody has to pay for it. If America's seniors are being asked to pay for half of it, that is not fair to America's seniors, given the commitment we have made to them. That is the point of the McCain amendment. Protect Medicare, protect America's seniors. We can do that with the simple amendment Senator MCCAIN has which is send the bill back to committee—it would only take 1 day—and send it back here without those Medicare cuts in the bill.

Mr. ALEXANDER. I see the Senator from Idaho here. I wish to hear his observations. If there is any issue in this entire health care debate that symbolizes why we on the Republican side want to change the debate to a step-by-step approach to reducing the cost of premiums, it would be the Medicare issue. As the Senator from Arizona said, what we need to do about Medicare is make it solvent as quickly as we can, as effectively as we can. The Senator from Kansas said the other day that the proposal to take $465 billion from grandma's Medicare and spend on it some new program is like writing a check on an overdrawn account in a bank to buy a big, new car. There is a lot of truth to that.

The President said earlier this year something I agree with. He said this health care debate is not just about health care. It is about the role of the Federal Government in the everyday life of Americans. He is exactly right about that. This health care debate, which we are beginning this week, is not just about health care. It is about the stimulus package, about the takeover of General Motors. It is about the trillion dollar debt. It is about the Washington takeovers. It is about too much spending, too much taxes, too much debt. The Medicare provisions in this bill are a perfect symbol of that. That is why Senator MCCAIN is right. What he is saying is, don't cut grandma's Medicare and spend it on some new program. If you can find some savings in the waste, fraud, and abuse of grandma's Medicare, spend on it grandma. Make sure those of us who are older and those of us who are younger and looking forward to Medicare can count on its solvency.

Later this week we will talk more about premiums going up. There was a lot of discussion yesterday because, according to the Wall Street Journal, some health premiums would rise. For people who get their insurance from large employers, this bill won't make much difference. And for small employers, if you get your insurance from a small employer, it won't make much difference. If you are going to the individual market to buy insurance yourself, your premiums will go up, except we are going to get some money from somewhere to help pay part of your premiums, at least for about half of Americans who are in the individual market. Where are we going to get that money? From grandma. We are going to get it from Medicare. So that is what is wrong with this bill. And what is right about the McCain amendment is, it says simply, don't cut Medicare. If we find savings, which we hope we can in Medicare, we should spend it on making Medicare solvent.

I wonder if the Senator from Idaho is hearing from seniors in his State about the proposed $465 billion cuts to Medicare and how they feel about taking that money and spending it to create a new program?

Mr. CRAPO. I thank the Senator from Tennessee. Very definitely we are hearing from seniors in Idaho who see through this. It is very clear to the

folks in Idaho that what we are seeing is a proposed massive growth of the Federal Government by over $2.5 trillion, when fully implemented, that is to be funded on the backs of American taxpayers and senior citizens through cuts in Medicare. In fact, in addition to those who have contacted me who are seeing their health benefits lost, I have also been contacted by a number of the providers. We are talking about those who are in home health care or hospice health care, skilled nursing facilities or hospitals and the like.

They make a very interesting point. Their point is that not only will senior citizens—in Medicare Advantage in particular—literally be losing their benefits dramatically, but that other senior citizens who are in traditional Medicare will also be losing access and quality of care. How is that the case? We know from the details of this bill that we are going to see major cuts in hospice care, home health care, skilled nursing facilities, and hospitals.

The points made to me by those providers are that they have already gone through a series of very deep cuts, cuts to the point that in Idaho for home health care, we have lost something like 30 percent of our facilities already. The way one of them explained to it me was that if you reduce the compensation we are receiving, then we have to reduce something in our budget. He said: We can't just start taking bricks off of our buildings. What we will end up having to do is to reduce personnel. That would be the nurses and the doctors and the other care providers who are there to provide support for these individuals. We will have to reduce the number of rooms we operate or the facilities we provide. In the end, there will be a reduction of services and access available to senior citizens, including a reduction in the quality of the care they are able to be provided.

Mr. ALEXANDER. In discussing the Medicare cuts, another provision of the bill which we will be talking about this month and next month as we go through the health care debate is what about the problem of paying doctors and hospitals who see Medicare patients. They get paid about 83 percent of the rate they would be paid if they were seeing a private care patient. Every year Congress has to make an adjustment in something we did a few years ago which automatically cuts the amount of money that we pay doctors who are seeing Medicare patients.

That is a big problem for Medicare patients. Because if the doctors can't be paid, they won't see the patients, and Medicare patients may find themselves increasingly in the condition that Medicaid patients do, low-income Americans who are covered through the State program—that is our largest government-run program—where they are paid about 60 percent of what doctors who see private patients are paid and about half of Medicaid doctors won't see new patients.

I ask the Senator, does he see anywhere in this bill a provision for the $¼ trillion that will be needed to pay doctors 10 years from now what they are making today? If it is not in the bill, where is that $¼ trillion going to come from? Is it going to come from Medicare cuts, or will it come from adding to the deficit?

Mr. CRAPO. Obviously, it will come from cuts in Medicare or increased taxes or simply more debt on the Federal level.

The Senator raises a very interesting point. This question of fixing the compensation rates for physicians in Medicare is a huge question, one which we have been fighting for for a number of years to try to find a solution to, as each year we delay the expected cuts that will happen. I have talked about this factor in the context of being a budget gimmick in this bill. What do I mean by that? Those who say this bill reduces the deficit are able to say so only because it has about $500 billion of new taxes, about $500 billion of Medicare cuts, and a number of budget gimmicks that delay the implementation of the spending side of the bill or, in this case, don't even include at all one of the major expenses that needs to be accommodated, and that is the fix for physician compensation. If any of those things were not in this bill, this bill would drive up the deficit tremendously.

What we are going to see, in addition to these fiscal impacts on the Federal Treasury in terms of huge increases in the debt or huge increases in more taxes, even more than we are talking about with this bill, is we are going to see the very real potential that access to medical care for seniors will be again reduced because of this factor.

Let me give a couple of statistics. In their June 2008 report, the Medicare Payment Advisory Commission, or MedPAC, said that 29 percent of Medicare beneficiaries who were surveyed were looking for a primary care physician and had trouble finding one to treat them. In other words, about 30 percent of Medicare beneficiaries today are having trouble finding a physician who will take a Medicare patient. That is before the $465 billion of cuts and before simply not including physicians at all in this legislation.

A 2008 survey by the Texas Medical Association found that only 58 percent of the State's doctors took new Medicare patients, and only 38 percent of the primary care doctors accepted new patients. Again, it is an example from MedPAC and from one State that indicates what we know is happening around the country; namely, that doctors in increasing numbers are no longer taking new Medicare patients, just as they have been doing with Medicaid patients for years. Yet we see these massive cuts to Medicare being proposed that will have the same impact on hospice care and home health service and skilled nursing facilities and hospitals, and we see that doctors are not even included at all, meaning they are projected now to receive major reductions. I think it is over 20 percent reduction in their compensation for taking Medicare patients.

The solution here to establishing a massive new Federal entitlement program is not to cut Medicare. I want to repeat something both the Senators from Arizona and Tennessee have already said that is critical. Reducing the Medicare budget by $464 billion, by any number, is something that has been encouraged in terms of trimming the growth path for Medicare. That is something this Congress has looked at in the past. But never was it intended by those who made these projections about needing to control the spiraling cost of Medicare that we address the fiscal circumstances in Medicare with the intended purpose of creating another new, massive Federal entitlement program that will grow the Federal Government by over $2 trillion—we talked about the numbers; the full 10-year period is $2.5 trillion—and leave Medicare with these dramatic cuts, this loss of service and loss of benefits to the recipients, while they see this new government growth with a new government program. That was not in the mind of anybody who was asking us to deal with the solvency issues on Medicare, and I don't think it was in the mind of anybody who asked that we have some kind of health care reform to deal with the rising cost of premiums.

Mr. ALEXANDER. Mr. President, how much time remains on the Republican side?

The ACTING PRESIDENT pro tempore. The Senator has 8½ minutes.

Mr. ALEXANDER. Would the Chair let me know when 4 minutes remain.

The Senator from Idaho will conclude our remarks at that time.

The Senator from Idaho has made an important point, anticipating our Democratic friends will have the next 30 minutes and some other things they may be saying the rest of the day. There was a lot of talk yesterday about the CBO report about the effect of this $2.5 trillion proposal on premiums. Rather than take my word for it, let's go to the news section of the Wall Street Journal of today which has the headline: ''Some Health Premiums to Rise.'' That means going up. That means the cost of your insurance is going up for some Americans.

So my question is, why would we spend $2.5 trillion over 10 years, cut Medicare, raise taxes, and run up the debt to raise some health premiums? I thought the whole exercise was to lower the cost of health care premiums.

The article says:

> The analysis released Monday by the nonpartisan Congressional Budget Office and the Joint Committee on Taxation—

We are supposed to pay some attention to these outfits as nonpartisan—

> painted a more complicated and uncertain picture. It said people who pay for their own insurance would see a higher bill, albeit for more generous benefits—

That is the government-approved insurance you are going to be forced to buy.

unless they are lower earners who qualify for a new government tax credit.

Where is the money going to come from for those subsidies? It is going to come from grandma. It is going to come from Medicare. It is going to come from taxes. And it is going to come from increasing the debt.

Those are facts.

Employees of small firms—

Says the Wall Street Journal—

would effectively see their insurance premiums unchanged—

So for small firms, we are going to spend $2.5 trillion over 10 years, cut Medicare, cut taxes, and run up premiums for millions of Americans, so your insurance will continue to go up at about the rate it already was. Why should we be doing that?

while workers at large firms would see something between unchanged and slightly lower premiums under the bill—

Compared to what would already happen—

according to the analysis.

We need to change the debate. We need to start over. Instead of this comprehensive 2,000-page bill that is full of taxes, mandates and, as a general effect, raises premiums and taxes and cuts Medicare, we should set a clear goal, reducing costs, and begin to go step by step toward that goal—reducing junk lawsuits against doctors, allowing health care to be purchased across State lines to increase competition, allowing small businesses to combine in health plans so they can offer more insurance to employees at a lower cost.

These three bills I mentioned have been offered and rejected so far by the Democratic majority. We should have more flexibility in health savings accounts, efforts at waste, fraud, and abuse, which are, in effect, Medicaid—the largest government program—and Medicare—the second largest—and more aggressive steps to encourage wellness and prevention.

One approach, the comprehensive 2,000-page bill, Washington-takeover approach, Americans are very leery of. In my respectful opinion, this bill is historic in its arrogance for thinking we could take a system that affects almost all 300 million Americans, 16 percent of the economy, and change it all at once.

Instead, why don't we go step by step to re-earn the trust of the American people? Republicans will be making those proposals on the floor this month and next month and as long as it takes to try to see that we get real health care reform. Cutting grandma's Medicare by $½ trillion and spending it on a new program at a time when Medicare is going broke is not real health care reform.

Mr. CRAPO. Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. There is 4½ minutes remaining.

The Senator from Idaho.

Mr. CRAPO. Thank you, Mr. President. I wish to conclude with our time this morning by focusing on the larger picture a little bit, as my colleague from Tennessee has done in his concluding remarks.

When you ask Americans whether they want health care reform, the vast majority would say yes. When you ask them what they mean by that, the vast majority in the polls and in my personal experience are saying: We want to see the spiraling costs of health care and our health insurance brought under control and reduced, and we want to see increased access to quality health care for those who do not have access today and for those who have limited access today.

This bill fails on those two central points. What this legislation does, instead, is increase the size of government by $2.5 trillion of new Federal spending, establishing massive new Federal controls over the economy, and even creating a Federal Government insurance company. It increases taxes by about $500 billion, and not just on the so-called wealthy. The vast majority of these taxes is going to squarely hit those who President Obama said would not be hit: those who make less than $200,000 a year and, frankly, all the way down the income chain.

It cuts Medicare by $464 billion. It puts a major new unfunded mandate on our States, which are already struggling in their fiscal budgets. As my colleague indicated, it causes the price of insurance premiums to go up for the individual market, to go up in the small group insurance market, and to be basically unchanged in the large insurance market, according to the CBO study.

By the way, one of the things that is not pointed out in that CBO study very much is in that large market, which it says will be the only part of the market that does not see insurance rates go up, one of the reasons is because their health care will go down. In other words, there is a tax on these larger, high-cost insurance premiums that is going to be either passed through and cause their insurance to go up or will be avoided by reducing the cost of their insurance and reducing coverage of the benefits in these policies. So one way or the other, all Americans are going to see their health care premiums go up or, in the large groups, see their health care premiums be held the same by reducing the quality of the insurance they have.

If you go back to those two reasons Americans wanted health care reform, did we see premiums go down? No. Did we see increased quality or increased access to care? Well, there are some who are going to get a subsidy in this program for this new massive Federal program. But at what price? Mr. President, $2.5 trillion, $464 billion of cuts in Medicare, the establishment of a major new government program that would essentially be funded on the backs of massive new tax increases, massive Federal tax increases, and Medicare cuts, and in the end we will still be in a system in which we are seeing spiraling increases in health care costs. To me, that is not the kind of reform we need.

My colleague from Tennessee indicated there are a number of reforms on which we can find common ground that will reduce health care costs. There are a number of reforms on which we can find common ground that will help us to increase access to quality care. That is where our focus should be. That is why I stand here today in support of my colleague JOHN MCCAIN, his motion to commit this legislation to the Finance Committee. As was indicated, it could be done in 1 day, to simply remove the Medicare cuts that are contained within it. Let's fix that part of this bill, and then let's work forward.

I see my time has expired. I encourage this Senate to focus closely on the legislation and to let us work together in a bipartisan fashion rather than speeding ahead and trying to pass legislation that has not had the opportunity for this kind of bipartisan effort to develop a good work product for the American people.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut.

Mr. DODD. Mr. President, our colleague from Maryland, Senator MIKULSKI, I believe is on her way to the floor of the Senate. She and several other Members, in the time we have allocated to us between now and 11:30, will address her amendment she proposed yesterday. But pending her arrival, I want to respond, if I could, very briefly to some of the conversation here this morning.

First, I know some people have short memories, but I am somewhat intrigued to hear our good friends and colleagues talk about preserving Medicare. I have been around here a few years and recall very vividly the debates of 1995 and 1997 on the issue of Medicare, where our friends, who were in the majority in those days, were talking about slowing the growth of Medicare and one of the proposals they had for doing so was to cut into the benefits of Medicare recipients.

We do not do that in this bill at all. Quite to the contrary, despite the language about ''big cuts in Medicare,'' we strengthen the Medicare Program substantially. That is the reason the AARP and other major organizations involved with the elderly have endorsed our proposals. They would hardly be doing so if they thought this was some massive cut into the Medicare Program that has been so critical to so many of our fellow citizens.

Just for a little bit of history here—In 1995 our Republican colleagues proposed cutting benefits to Medicare beneficiaries. Newt Gingrich, our former Speaker and friend from the other body, was quoted as saying ''let's let Medicare wither on the vine.'' That is not ancient history. That is not 1965.

That is just a few years ago in all of this debate.

There are some very strong provisions in the bill that reduce premiums and co-pays for seniors, ensure seniors are able to see their own doctors, and keep Medicare from going bankrupt for an additional 5 years. If we adopt the McCain amendment, we are being told today by CBO and others that Medicare becomes insolvent in 8 years. So vote for the McCain amendment and you are going to have an insolvent program in 8 years. That is a fact.

We extend the life here an additional 5 years. We provide new preventive and wellness benefits for seniors, lower prescription drug costs, allow seniors to stay in their homes and not end up in nursing homes.

This is a long bill. It is a big bill. But instead of complaining about its size, I would encourage my colleagues to read it and understand what is being done for Medicare. This is a complicated area, but, nonetheless, critically important.

Mr. President, I see my colleague from California, Senator BOXER, who is here, and others who want to address the issue of the Mikulski amendment, and I will yield the floor so they can be heard. I believe it is going to be each for 5 minutes. There are about seven of our colleagues who want to be heard on the issue before 11:30.

Mrs. BOXER. Mr. President, if I might respond.

The ACTING PRESIDENT pro tempore. The Senator from California is recognized.

Mrs. BOXER. The plan is, women colleagues will be coming to the floor. As they come, I will yield to them, until Senator MIKULSKI gets here, and then she will yield the time, if that is all right.

Mr. DODD. Very good.

Mrs. BOXER. Mr. President, before I start, I want to say to my colleague from Connecticut how much I appreciate his work and the work of Senator BAUCUS and Senator REID. What a remarkable moment we have here.

When I go home—and I was home for the holidays—people are urging us to get this done. They know their biggest chance of going into bankruptcy is a health care crisis—62 percent. They know, as my friend Senator DODD has said almost every day of this debate, every morning 14,000 people lose their health care. They know if we do not intervene with a good bill, their premiums—in my home State, I say to the Senator—will be 41 percent of their income, the average income, by 2016.

Can you imagine? That is unsustainable. For people who say: Why don't we address the economy instead of health care, let me say what happens to my constituents if they have to pay 41 percent of their income for premiums. Even if they have a good job, I say to my friend from Connecticut, they cannot make it. So the status quo is cruel, and it is particularly cruel to women.

AMENDMENT NO. 2791

Mrs. BOXER. Mr. President, I am proud to support the Mikulski-Harkin-Boxer amendment to improve preventive health coverage for women. The Mikulski amendment addresses this critical issue by requiring that all health plans cover comprehensive women's preventive care and screenings—and cover these recommended services at little or no cost to women. These health care services include annual mammograms for women at age 40, pregnancy and postpartum depression screenings, screenings for domestic violence, annual women's health screenings, and family planning services.

The preventive services covered under this amendment would be determined by the Health Resources and Services Administration to meet the unique preventive health needs of women. HRSA is an agency within the Department of Health and Human Services. HHS Secretary Kathleen Sebelius has already said that ''Mammograms have always been an important life-saving tool in the fight against breast cancer and they still are today.'' The Secretary made clear that recommendations by the U.S. Preventive Services Task Force ''do not set federal policy and they don't determine what services are covered by the federal government.''

This is not the first time that experts have disagreed about this issue. I have been in this battle before, with Senator MIKULSKI, who called a hearing with all of the women Senators in 1994 where I insisted that routine mammograms for women over 40 must be covered. And thank goodness we fought back then, and in 1997 and in 2002 when this issue was raised again and again. Since 1991, the death rate from breast cancer has been reduced by over 20 percent.

According to a 2007 Partnership for Prevention report, 3,700 additional lives would be saved each year if we increased to 90 percent the portion of women age 40 and older who have been screened for breast cancer in the past 2 years. The most recent data show us that approximately 17 percent of breast cancer deaths occurred in women who were diagnosed in their forties. That is why the American Cancer Society continues to recommend annual screening using mammography and clinical breast examination for all women beginning at age 40. Mammograms are still the most effective and valuable tool for decreasing suffering and death from breast cancer. The Mikulski amendment will ensure women are able to get access to this and other life-saving preventive services at no cost.

The underlying bill introduced by Senator REID already requires that preventive services recommended by the U.S. Preventive Services Task Force be covered at little to no cost. These recommendations already include some women's preventive services such as osteoporosis screenings.

But they do not include certain recommendations that many women's health advocates and medical professionals believe are critically important, such as screenings for ovarian cancer—a disease that will claim the lives of nearly 15,000 women this year. We know that when ovarian cancer is diagnosed early, more than 93 percent of women survive longer than 5 years.

Women are often the decisionmakers for their families when it comes to health care. But women too often put the health needs of their family members and their children ahead of their own.

By passing this amendment, we are saving the lives of countless mothers, daughters, grandmothers and sisters who would otherwise forgo preventative health care because of high copays and expensive deductibles.

I would like to share with my colleagues a story from a doctor in my home State of California, William Leininger, that drives home the importance of this amendment:

> In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship, and she lost her health insurance when they divorced.
>
> For the next five years, she had no health insurance and never received follow-up care (which would have revealed that her cancer had returned). She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread.
>
> She had two children from her previous marriage—her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her kids after her death. She succeeded. She was 28 when she died.

That is not a story that should be told in the richest nation in the world.

As I said, I am so proud to support the Mikulski-Harkin-Boxer amendment to improve preventive health care coverage for women. Here is why. It is a fact that women are increasingly delaying or skipping altogether preventive health care, and they are doing it because of costs.

I read a statistic done by a nonpartisan group that said about 39 percent of men are delaying going to a physician to check on a problem. But over 50 percent of women are doing that either because they do not have health coverage or they are fearful of the copay. So we could sit here and do nothing—that is the easy thing to do: Scare people, do nothing—or we could step to the plate, save Medicare, which is very important to save, and that is what this bill does. Because we say we are not going to spend money on waste, fraud, and abuse. We are going to spend money on health care for our people.

And to believe that my friends on the other side are the ones who are going to save Medicare? You just have to read history. Senator DODD explained it; Newt Gingrich saying: Let Medicare wither on the vine; Bob Dole, our friend, who said, at the time of his Presidential campaign: I fought against Medicare. It was a failure.

Well, if you ask our seniors, I think they are the group most pleased with their coverage. It is not perfect, but it is critical, and we save it here. We extend the life of Medicare.

So here we are in a situation where many women are delaying going to the doctor, getting their preventive services, and the Mikulski amendment addresses this critical issue. It requires that all health plans cover comprehensive women's preventive care and screenings, and cover them at little or no cost.

The reason this is so important is—first of all, in the HELP Committee, under Senator DODD's and Senator Kennedy's leadership, this piece of the package was in the bill because Senator MIKULSKI and others pushed so hard to get it placed into the bill.

Mr. President, I would ask my friend from Maryland, Senator MIKULSKI, if I could complete my remarks and then give the floor over to her?

Mr. President, I thank the Senator.

I am so proud to work with Senator MIKULSKI. I say to the Senator, we worked on this issue over the years. I just asked my staff to go back and look at the first time we teamed up to ensure that women get mammograms at age 40. That was in 1994. Then, again, over the years, every 3 or 4 years, this whole notion would rear its ugly head: Well, women can do without mammography. The question I have is, What is going to replace it? They would keep trying to take away our tools of self-examination and mammography. We know if you look through the years—and Senator MIKULSKI and I are proud of a lot of the work we do, but this goes right at the top of the list—we know mortality for breast cancer is way down since the early 1990s. It is 20 percent down since the early 1990s. We have had to stand our ground to protect women, to make sure they get those services they need, those life-saving services, at little or no cost.

I would also say the American Cancer Society continues to recommend annual screening using mammography and clinical breast exams for all women beginning at age 40. There are a lot of other very important tests that are included in the Mikulski amendment—very important tests—to deal with cervical cancer and ovarian cancer, finding the markers so we know how to deal with these deadly diseases. To give up the tools we have, to turn it over to some organization that does not report to the Secretary of HHS, makes no sense.

What my friend has done with her amendment is to make sure the group that decides this is under the jurisdiction of the HHS Secretary. We know the HHS Secretary has already said she wants to make sure women, starting at age 40, get those mammograms.

I am going to close by reading from an article in the March 10, 1994, San Francisco Chronicle. It says:

> Joining what became a phalanx of six female Senators staring down at federal health officials Boxer said she will insist that routine mammograms and a host of other women's health needs be part of any new nationwide benefit package.

The article goes on. It is very clear. What I said at the time is:

> After all of these years of women being told it is crucial by age 40 to get a baseline mammogram, now to have this tremendous confusion hit us is very disturbing.

Well, it was disturbing on March 10, 1994, when I first got involved in this issue. It was disturbing when Senator SNOWE, 3 years later, had us pass S. Res. 47 which said this is our only tool. Let's do it. Thank goodness we have now in this body women and men who get the fact that we refuse as women to be stripped of the only tools we have. Making all of these important tests part of this package is going to save lives. It is going to save money. It is going to mean our families can breathe a deep sigh of relief out there.

So I wish to thank Senator MIKULSKI for her leadership on this issue and to always stand right at her side on this issue of mammography. We also worked on standards for mammography. Remember that one? It was the deregulation fever that hit the Republican side. They wanted to take away the regulations for mammography, roll them back. We fought the fight, and we will continue to fight the fight.

So thank you very much. I strongly support this amendment.

I yield the floor for my friend, Senator MIKULSKI.

The ACTING PRESIDENT pro tempore. The Senator from Maryland is recognized.

Ms. MIKULSKI. Mr. President, as we debate health care reform, we need to recognize in the United States of America that health care is a women's issue. Health care reform is a must-do women's issue, and health insurance reform must be a must-change women's issue.

Too often when we look at when health care is even available to us, we face discrimination. We face continually the punitive practices of insurance companies that charge women more and give us less in a benefit. A 25-year-old woman pays more for health insurance than her male counterpart of the same health status. A 40-year-old woman pays almost 35 percent more for her insurance than a male of the same age, same health status. We want to change that in health care reform. We want to end the punitive practices of the private insurance companies in their gender discrimination.

We, the women of the Senate, are concerned that even being a woman is being viewed by the insurance companies as a preexisting condition.

Now we have the opportunity to change the law and change the direction of health care. I have offered an amendment to expand the screening and preventive services available to women in order to save our lives, make sure our lives are not impaired as we get older and, at the same time, be able to save money. We know early detection saves lives, curtails the expansion of disease, and, in the long run, saves money.

There are certain killers of women, the dread ''c'' word, cancer—breast cancer, ovarian cancer, cervical cancer that are unique to we women. Then there is the dread disease of lung cancer that affects men and women but is emerging as a main killer of women. Then there is the other issue of heart disease and vascular disease. We know for years women were often left out of the research on heart disease. For years women's heart disease went undetected and unrecognized because our symptoms are different. We can change this law.

In my amendment we expand the key preventive services for women, and we do it in a way that is based on recommendations from the Centers for Disease Control and from HRSA. It will be based on the benefit package available to Federal employees. It means if our amendment passes, the women of America will have the same access to preventive and screening services as the women of Congress. What is good enough for a United States Senator should be good enough for any woman in the United States of America.

That is why we ask not only the women to join us but the good men of quality who support us. We know people such as Senator DODD, Senator REID, Senator BAUCUS, men of quality, never fear we women who seek equality. They have raced for the cure as long and as hard as we have and have fought for mammogram standards. This is why we are wearing pink today. Pink is the universal color that says while we race for the cure, we want to have access to it when we find it. But to have access to the cure, we are going to need to have access to mammograms to be able to get that diagnosis, and then we are going to have to have health insurance to be able to pay for the treatment we have.

This is the Titanic battle we have today: Are we going to have access to health insurance and are we going to have access to these preventive services?

We do know in the area of heart disease and cancer and silent, undetected killers such as diabetes, it is often undetected. What happens is, for many women they do not get that early detection and screening, No. 1, because they can't afford it. They can't afford it because they either don't have health insurance and there are other demands on their family or, No. 2, when they go, if they do have insurance, they find their benefit might not be covered. So many of these benefits are based on State mandates, but worse than that it is the copayments and high deductibles.

Many women say: Well, my insurance company provides for it, but this copayment and deductible, I have to choose between my children's shoes or my deductible. We want to either

eliminate or shrink those deductibles and eliminate that high barrier, that overwhelming hurdle that prevents women from having access to these early detection and screening programs.

Much is being debated about mammograms. We believe access to mammograms should be universal, universal access. But the decision on whether to get one should be made with your doctor. Well, that is great to say, but you need to have access to your doctor. You need to not have to overcome the high hurdle of deductions or copayments to be able to do it.

We know mammogram screenings decrease breast cancer by over 40 percent. Regular pap smears reduce cervical cancer by 40 percent. This year, 4,000 women will die of cervical cancer. Then let's take the dread, but often overlooked, diabetic screening. Diabetes is the underlying cause of two-thirds of chronic illness in both younger and older women. If we find it early and get everybody in the right program, they are going to be able to get the treatment they need so they don't lose an eye, they don't lose a kidney, they don't lose a leg.

We can't lose any more time. We need to provide universal access to health care to the American people and we need to make sure they have access to the screening and early preventive actions that will save lives.

Mr. President, I urge the adoption of the Mikulski amendment, and I thank you for your leadership on this issue.

I ask unanimous consent that the remaining time be equally divided between Governor SHAHEEN, Senator HAGAN, Senator MURRAY, and Senator GILLIBRAND.

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

Who seeks recognition?

The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, I rise today in support of Senator MIKULSKI's amendment to ensure that women have access to preventive health care screenings and care at no cost. I wish to thank Senator MIKULSKI for her leadership not just in this effort but over the years to make sure women are treated fairly when it comes to our health care.

As a woman, a mother of three daughters and a grandmother of three granddaughters, this is an issue that is critically important to me personally. But as a former Governor, now a Senator and a policymaker, I understand these preventive services are not just good for women but they are good for families—for the children and husbands and brothers and fathers of the women we are talking about today. This amendment is good for our society as a whole.

Women must have access to vitally important preventive services such as screenings for breast cancer, cervical cancer, pregnancy, and postpartum depression screenings, annual well-woman visits, and preconception counseling that promotes healthier pregnancies and optimal birth outcomes. It is the right thing to do, but it is also fiscally responsible.

Not only does diagnosing disease early significantly increase a woman's chance for survival, but it also significantly decreases the projected costs of treatment. In fact, one recent study estimated that almost 80 percent of all health care spending in the United States can be attributed to potentially preventable chronic illness. This amendment takes a great step forward to early diagnosis of these costly and potentially preventable diseases. We must ensure these important services are provided at no cost.

Too often, women forgo their health care needs because they are not affordable. We know cost plays a greater role in preventing women from accessing health care than it does men. In 2007, more than half of all women reported problems accessing needed health care because of costs.

It is clear we need to support Senator MIKULSKI's amendment that will give women access to important health care screening.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mrs. GILLIBRAND. Mr. President, I rise in support of Senator MIKULSKI's amendment, which improves the health care measures that are already in this act.

Women must shoulder the worst of the health care crisis, including outrageous discriminatory practices in care and coverage. Not only do we pay more for the coverage we seek for the same age and the same coverage as men do, but in general women of childbearing age spend 68 percent more in out-of-pocket health care costs than men.

Some of the most essential services required by women are currently not covered by many insurance plans, such as childbearing, Pap smears, and mammograms. A standard in-hospital delivery can cost between $5,000 and $10,000 and much more if there are complications. You cannot imagine what it is like for a pregnant woman to recognize she may not have coverage for the essential services she needs for herself and her child. The health care bill before us ensures that this will no longer happen.

However, there is much room for improvement. In America today, too many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost.

This fundamental inequity in the current system is dangerous and discriminatory and we must act.

The prevention section of the bill before us must be amended so coverage of preventive services takes into account the unique health care needs of women throughout their lifespan.

With Senator MIKULSKI's amendment, even more preventive screening will be covered, including for postpartum depression, domestic violence, and family planning.

Covering more preventive screening at no cost to women will encourage that more women go to the doctor, improving their health, saving lives and, as Senator MIKULSKI brought out, saving money.

The whole point of this health care bill is to lower costs across the board. When you shift America's health care system to preventive services over the current emergency room services, you are going to do exactly that.

This amendment will ensure that the coverage of women's preventive services is based on a set of guidelines developed by women's health experts.

This amendment will also preserve the doctor-patient relationship, to allow the patient to consult with their doctor on what services are best for them.

This amendment will cost $490 million over 10 years and it is fully paid for.

The health care crisis in America must be addressed, and I am very supportive of Senator MIKULSKI's amendment.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mrs. HAGAN. Mr. President, I rise in support of the amendment offered by the senior Senator from Maryland.

This amendment tackles a serious problem: Women are increasingly skipping critical preventive health care screenings because of costs, even when they have health insurance.

This summer, I received an e-mail from a woman named Julie in Raleigh, NC, about her sister who had no insurance and waited years to get a mammogram because she couldn't afford to pay the $125 fee for a mammogram. Then she found a lump in her breast.

Eventually, the mass grew so large Julie's sister finally got her mammogram and paid for it with cash. The mammogram confirmed what she had suspected, that she had breast cancer. But now that she had a diagnosis, she had no way to pay for the treatment.

She lost her battle with breast cancer in March of this year. Julie's sister, perhaps, could have beaten this cancer if she had had access to affordable, preventive care and, after her diagnosis, access to insurance or medical care to cover her cancer treatment.

In this heartbreaking situation, Julie's sister was sick and stuck. This health care reform bill will provide people such as Julie's sister with access to affordable, quality health insurance.

The President of Randolph Hospital in Asheboro, NC, wrote to me recently that a few years ago, he was in a meeting with 20 to 30 of his nursing assistants who were covered by the hospital's insurance plan. Of those who were old enough to require a mammogram, only 20 percent had actually gotten one. The reason, they said, was the

high out-of-pocket costs they would have to pay.

When these women had to choose between feeding their children, paying the rent, and meeting other financial obligations, they skipped important preventive screenings and took a chance with their personal health.

The hospital then decided to remove the financial barrier to preventive care and pay for 100 percent of preventive screenings.

With the passage of Senator MIKULSKI's amendment, we will do the same for all women. A comprehensive list of women's preventive services will be covered with no added out-of-pocket expenses.

With this amendment, we will ensure that, as the old saying goes, ''An ounce of prevention is worth a pound of cure,'' for women across America.

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

Mrs. MURRAY. Madam President, I add my thanks to the Senator from Maryland, Ms. MIKULSKI, for bringing forth this important issue as we address health care reform in this country to ensure that all our families have access to health care.

One of the most important things we can do is make sure the caregivers in our families—the women—get access to preventive care so they can take care of their families.

This amendment will require all the health plans to cover comprehensive women's preventive care and screenings at no cost to women. That is extremely important. We all understand that—but especially in these tough economic times, when families across the country are struggling. One of the results has been that a lot of women are skipping or delaying their health care. We all know this personally. As moms, you take care of your kids first. When you do that, you often leave your families at risk because you haven't gotten the necessary preventive care.

We know that, in 2007, a quarter of women reported delaying or skipping health care because of the costs. In May of 2009, a report by the Commonwealth Foundation found that more than half of women delayed or avoided preventive care because of its cost.

This amendment will ensure that those women don't delay their preventive care because they cannot afford it. It is extremely important for this bill, it is important for women in this country, and it is important for men and children in this country as well.

I add my thanks to the senior Senator from Maryland and all our Senate colleagues who have been down here to make sure that one of the first things we do as we move the bill to the floor is make sure women's preventive care is covered.

I yield the floor.

Ms. MIKULSKI. Madam President, that concludes our discussion and our responses to this portion of the health care reform bill.

I must say: Alert, alert, alert. We have just been informed that a shrill advocacy group is spreading lies about this amendment. They are saying that because it is prevention, it includes abortion services. There are no abortion services included in the Mikulski amendment. It is screening for diseases that are the biggest killers for women—the silent killers of women. It also provides family planning—but family planning as recognized by other acts. Please, no more lies. Let's get off of it and save lives.

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

The Senator from Montana is recognized.

Mr. BAUCUS. Madam President, I yield myself 1 minute. Very much straight to the point here, there has been some discussion about CBO's assessment on the health care premiums. The letter was out yesterday. That letter shows that for all Americans—all Americans—premiums will be lower. They will be modestly lower to those larger employers. We have a range between those small businesses of between a 1-percent reduction and a 2-percent increase, and for the individual market there is more variation because there is much more variation today currently in the individual market.

Those who purchase in the individual market will be getting a lot better quality of insurance than they are getting today—much better. About 60 percent of those in the individual market will find that their premiums are actually lower after the tax credit/subsidies are taken into consideration.

So netted all out together, all Americans are going to see their premiums are lower for what they get today. About 7 percent will see an increase, but they are getting better coverage than today—quite a bit better coverage. On a net basis, basically, bottom line, everyone were will see his or her premiums lower. For the 7 percent that are not lowered, they will get a lot better quality of insurance. That will more than offset the increase in premium. That is what that CBO letter says. I urge all folks who are interested to read that letter.

I have one other minor point on the so-called Cadillac plans. CBO said that those who receive Cadillac plans will find their premiums reduced, not increased—I think it is by about 6 or 7 percent. That, too, is very important. There has been a lot of discussion about the effect of premiums on Cadillac plans. CBO says those premiums will be reduced.

My minute is probably up. I wish to use the last seconds to just say that the net, all the way across the board, CBO says premiums will be reduced when you take subsidies into consideration and compare the plans people get today with what they would otherwise get in the future, the quality of coverage.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. Madam President, how much time remains on the Republican side?

The PRESIDING OFFICER. Three minutes.

Mr. COBURN. Madam President, I ask unanimous consent to consume that 3 minutes and the other 15 minutes allotted to our side on the executive nomination, and when that 18 minutes is up, the remainder be followed by the time on the Democratic side and the nomination be reported.

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

Mr. COBURN. Madam President, I wished to spend a few minutes on this.

As a physician who cared for Medicare patients for 25 years, I cannot tell you how worried I am about what this bill is going to do to my senior patients. When Medicare was first written, two things were put into the law—very straightforward, very direct. Let me read them to you, for a minute. I hope Americans listen to this. Here is what the law is. CMS is breaking the law today and, with the new Medicare Commission, they are going to break it even further under this bill.

Section 1801 says this:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

That says that the Federal Government cannot practice medicine. That is what it says.

Section 1802 says this—and this is where it is important for my Medicare patients and everyone out there:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

Well, what we have in this bill is the gutting of those two foundational principles of Medicare. The first is the Medicare Advisory Commission is going to tell you what you can and cannot have. Here is what we are going to see: You will choose what I tell you to choose if you are a Medicare patient.

Not only do we have almost $500 billion in cuts to Medicare, under the auspices that we have to control entitlement spending; not only are we taking away plans from people who are very satisfied with what they have today, but we have enhanced, and will enhance, the ability of the Federal Government to practice medicine.

My colleagues on the other side of the aisle, who have never practiced medicine, who know the legalese but don't know the consequences of right now the rationing of Medicare on drugs such as Epigen and Neupogen—you see, Medicare has decided when oncologists can use those drugs. They have taken a

blanket position, although they have released it somewhat. But what it says is this—I will give you a patient who has breast cancer. She is 67 years old. She is being treated for breast cancer. She becomes anemic and neutropenic. That means her white blood cell count, her ability to fight infection goes down.

We have wonderful drugs that raise the white blood cell count and raise the red blood cell count. But Medicare, in its obvious wisdom of practicing medicine, has told the oncologists when they can and cannot use it. That is fine for 75 percent of the patients, but it totally ignores the other 25 percent of the patients who happen to have complicating factors, such as congestive heart failure or if they become anemic under breast cancer chemotherapy and have congestive heart failure as well. The government says you cannot have erythropoietin at this level of hemoglobin regardless of whether you have congestive heart failure.

What happens is the practice of medicine out of Washington or Maryland, more specifically, determines who can and cannot have a drug; in this case, erythropoietin.

What is the consequence of that? The consequence is that the patient did not die of breast cancer; she died of congestive heart failure that could have easily been treated had we not had medicine practiced by CMS denying the ability of the physician to give the patient exactly what she needed when she needed it.

We are starting down that road with this bill—aggressively starting down that road—because the Medicare Payment Advisory Commission, combined with the Comparative Effectiveness Panel will not look at complications and will not look at secondary diseases. They will look at the average.

I want to tell my colleagues, when you are sitting in an office with your doctor, you are not average. You are you, and you are a specific individual with a set of factors that nobody else has. The judgment in the practice of medicine cannot be done by an insurance company or CMS at a distance without them having a hand on the patient. They never have their hand on a patient.

The whole art of medicine, which is 40 percent of getting people well, is the knowledge and training and experience and gray hair that comes with looking at the total patient, being one on one, not having the government between the doctor and their treatment of a patient.

What this bill does—this bill is a lie one of two ways. One, it says we are going to take this money out of Medicare and you are not going to notice any difference. That cannot be true. If we take $500 billion or $400 billion-plus out of Medicare, millions of seniors are going to notice a difference in their health care and what they get under Medicare. If we say that is not true, then the only way that is not true is the game that is being played on the financing of this program; that is to say, we are going to cut this money out of Medicare and then with a wink and a nod know we are never going to do it.

The majority leader said yesterday there is nothing more important in this Nation right now than passing health care reform. I differ with that statement. I think 10.2 percent unemployment is a whole lot more important, and finding those people jobs, than passing health care reform. I think a $12 trillion debt is more important to address than fixing health care right now. I think the fact that we have $350 billion worth of waste, fraud, and duplication in the Federal Government every year, and we are not addressing it, is more important than fixing health care right now. I think the fact that our economy is still on its back and people are continuing to lose jobs is more important than fixing health care right now.

I understand the political dynamics, but I also understand very well with my quarter of a century of practicing medicine that what this bill is going to do is destroy the best health care system in the world, and it is going to undermine the security of every senior in this country because what starts as a small couple of things, such as Neupogen and Epogen or like when you can have bone densitometry and whether your osteoporosis can truly be evaluated, CMS has already said how much you can do that, whether your bones are falling apart or not. It is the start of the government practicing medicine.

It is the beginning of our seniors having the government step in between them and their physician in terms of the physician wanting to do what is best for that senior and the government saying: No, I will tell you what you are going to have. I will tell you what you will have.

Thomas Jefferson taught us a lot. He predicted we would have ''future happiness for us if we can prevent the government from wasting the labors of the people under the pretense of taking care of them.''

I want to see a lot of things changed in health care. I want to see true competition in the insurance industry. I want to make sure nobody loses their insurance because they get sick. I want to make sure everybody can get insurance if they are sick. I do not disagree with the basic premise. What I disagree with is moving $2.5 trillion more under government control, which will raise costs ultimately in the health care sector. If it does not raise costs and we are truly going to take this money from Medicare, what it is going to do to our seniors, I have a message for you: You are going to die soon, and they are going to say that is not true, that it is not true.

When you restrict the ability of the primary caregivers in this country to do what is best for their senior patients, what you are doing is limiting their life expectancy. We are saying CMS, the Medicare Payment Advisory Commission, and the Comparative Effectiveness Panel will tell the doctors what they can and cannot do, ignoring the 20 percent of the people for whom that is exactly the wrong prescription. So for 20 percent of our seniors, this bill is going to be a disaster, but it is going to save money because you are not going to be around for us to spend any money on you because the government will have already told us what the treatment plan will be for you. We will decide in Washington through the Center for Medicare and Medicaid Services what you will receive.

They will dispute that, but the people who are going to be disputing that are lawyers; they are not doctors. They have never laid a hand on a patient. They have never put their hand forward on a Medicare patient knowing the consequences of the total patient, the background, the medical history, the sociologic factors that fit, the family dynamics, the past medical history, the family history, and the present state of mind of that patient.

Even more important, what this bill is going to do is divide the loyalty of your doctor away from you. When you go to the doctor today, most of the time that doctor's No. 1 interest is in you and your well-being. When you have this Medicare Payment Advisory Commission and you have this Comparative Effectiveness Panel, what that does is that causes the physician—he or she—to take their eyes off of you. Now they are going to put their eyes on what the government says because the consequences of not doing what the government says will ultimately result in some type of sanction.

Do we want physicians to be patient-centered and focused on their patients or do we want physicians to have their eye on the government and half of an eye on the patient? Which do you think is going to give us the best care? Which do you think is going to give us the greatest quality of life? What is going to give us the greatest longevity with the greatest quality of life? Is it the government practicing medicine, or is it the trust that has been developed through years between a patient and a doctor to do what is in the best, long-term interest of that patient?

I cannot tell you the number of people who die from the CMS regulations on Epogen for oncologists. But there were hundreds—hundreds—because Medicare never looked at the patient; they looked at dollars.

As we go forward in this debate, what I want seniors in America to know—and I am fast approaching Medicare age; I am 3 years from it—I want them to know the key thing they are going to lose in this bill is the loyalty and primacy of their physician thinking about them. We are going to divide that loyalty to where the physician is going to be looking at the government. If you think that is not true, just look at what has happened so far when CMS

has decided to start practicing medicine.

In the HELP Committee, I offered an amendment to change the language so there would be absolutely a prohibition on rationing care and directing the care from Washington. It was rejected out of hand—rejected out of hand. Not one of my colleagues on the other side of the aisle voted to prohibit rationing of health care.

Why would they do that? Because the ultimate intention through the Comparative Effectiveness Panel is to ration care. It is to ration the care. It is to limit the amount of dollars we spend and never look at the individual patient.

If we think about the Medicare cuts in this bill, we are going to take $135 billion out of the hospitals. Do you think seniors will ever notice that? I do. I think when you ring your button and you are hurting and you need pain medicines or you need to go to the bathroom, the time it takes for somebody to get there will not be sufficient. What will happen is you will wait. You will have a complication. If you have acute shortness of breath and press the button, the available nurses will not be there. There will be a consequence to cutting $135 billion from payments to hospitals in this country.

We are going to take $120 billion out of the seniors—the one in five seniors who now have Medicare Advantage. I agree, it is more expensive than Medicare. It needs to have some cost containment through competitive bidding, but we should not be decreasing the services, which is exactly what is going to happen. If you are a senior on Medicare Advantage, you are going to lose benefits you now have. You are going to lose them.

One of the ideas of Medicare Advantage was preventive services. One of the things that improved the care in rural America was Medicare Advantage. Yet we are going to take that away. The vast majority of the benefits we are going to cut in half.

We are going to take $15 billion from nursing homes. That may or may not be appropriate, but the way to do that is through a competitive experience based on quality and outcome rather than some green-eyeshade staffer saying we can take $15 billion out of Medicare from payments to nursing homes.

One little secret that is not in this bill, that has not been addressed in this bill, is the estimate by a Harvard researcher that there is $120 billion to $150 billion a year in fraud in Medicare alone. HHS admits to $90 billion. We know it is well over $100 billion a year. Cleaning up the fraud in Medicare would pay for a lot of health care for a lot of folks in this country. There is $2 billion in this whole bill to clean up the fraud.

Why would we not fix that first? Why would we take money from Medicare to create a new program when in fact we are wasting 10 to 15 percent?

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

Mr. COBURN. I will close with this remark. If you are a senior and you are on Medicare, you better be afraid of this bill. I don't come to the floor and say that very often, but your health care is totally dependent, in terms of being decreased by this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Madam President, I ask unanimous consent I be allowed to speak for 1 minute 7 seconds and the time be taken from that of my good friend and colleague from Vermont, the chairman of the Judiciary Committee.

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

Mr. DODD. Madam President, Senator TOM COBURN and I have become great friends. We have spent a lot of time together this summer in my HELP Committee. He talked with great eloquence about that distance that can occur between a doctor and patient, and obviously as someone who practiced medicine for a long time, he speaks from strong personal experience, and I admire and respect that immensely. But let me say to my colleagues, without this bill we are talking about here, this comes to a simple choice. Under existing law, the way things are today, one institution stands between a doctor and patient and that is your insurance company. They ration care all the time. In fact, I am a living example of rationed care, having been through surgery, getting preapproval twice before surgery and then being rejected by the very insurance company I paid premiums to for a long time as a Member of this body. We are working it out, I believe, because they thought—I am 65—that Medicare ought to pay for my surgery rather than the company I paid premiums to for a long time.

They were rationing my care. That insurance company, it wasn't some government entity or someone else, they are the ones. Without our bill, the only one getting to decide what health services anyone receives is the insurance industry.

I hope we would have a chance to debate this further, as I am confident we will.

Let me also say how much I support the effort by Senator MIKULSKI on her efforts to see to it that women are treated equally, and particularly in preventive care, and I strongly urge the adoption of her amendment and ask to be added as a cosponsor to that amendment.

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

Mr. DODD. I thank the Chair.

Mr. LEAHY. Madam President, our Nation is in the midst of a historic debate about how to reform our health insurance system. Three House committees and two Senate committees have spent countless hours trying to answer the question of how best to introduce competition and make health insurance affordable for all Americans. I applaud their efforts, and I applaud the efforts of the many Senators who have fought to bring this important debate to the Senate floor.

I have pushed and will continue to push for provisions that accomplish the ''three C's'' of health insurance reform: choice, competition, and cost control. I recently reaffirmed my support for a public option.

A public option would give consumers more choices to purchase an affordable and quality health insurance plan and will help drive down overall health care costs. I will continue to push for inclusion of a public option in the final Senate bill.

Amid this discussion of how best to introduce competition into the health insurance industry, it is important to remember that today the health insurance industry does not have to play by the same rule of competition as other industries. Due to a six decade-old special interest exemption, the business of insurance is not subject to the Nation's antitrust laws. If there was ever a good reason for such an exemption, it no longer exists.

While there are divergent views on the best way to introduce choice and competition into health insurance market, we can surely agree that health and medical malpractice insurers should not be allowed to collude to set prices and allocate markets.

Today, I am filing the Health Insurance Industry Antitrust Enforcement Act of 2009 as an amendment to the Patient Protection and Affordable Care Act. This legislation, which I introduced in September and which is cosponsored by 18 Senators, will repeal the antitrust exemption for health insurance and medical malpractice insurance providers, and ensure that the basic rules of fair competition apply to the industry as part of the reforms that the larger health care bill will enact. Our Nation's antitrust laws exist to protect consumers, and it is vital that the health insurance and medical malpractice insurance companies are subject to these laws.

These laws promote competition, which ensures that consumers will pay lower prices and receive more choices.

The Majority Leader, an original cosponsor of this legislation, testified before the Senate Judiciary Committee that ''[i]t is of the upmost importance that we make sure the insurance industry is playing by the same rules as everyone else, and that they are subject to competition.'' I could not agree more, and I encourage the leader to schedule a vote on this amendment early in this debate. The President also recently supported Congress's efforts to determine whether any justification remains for permitting price fixing.

The vast majority of the companies doing business in the United States are subject to the Federal antitrust laws.

However, a few industries have used their influence to maintain a special, statutory exemption from the antitrust laws. The insurance industry is

one of those few remaining industries. In the markets for health insurance and medical malpractice insurance, patients and doctors are paying the price, as costs continue to increase at an alarming rate, while patients and small businesses suffer. This is wrong, and this amendment fixes this problem.

The Health Insurance Industry Antitrust Enforcement Act is supported by a cross-section of groups interested in promoting competition, including the Consumer Federation of America, Health Care for American Now, and the American Hospital Association. I also received a letter from a coalition of 10 State attorneys general who voiced their specific need for this legislation.

The top law enforcement officers in those States argue that ''Repeal of the McCarran-Ferguson exemption would enhance competition in health and medical malpractice insurance by giving state enforcers, as well as federal enforcers, additional tools to combat harmful anti-competitive conduct.'' The letter goes on to state that ''The McCarran-Ferguson exemption serves no plausible public interest.''

This amendment will prohibit the most egregious anticompetitive conduct—price fixing, bid rigging and market allocations—conduct that harms consumers, raises health care costs, and for which there is no justification. Subjecting health and medical malpractice insurance providers to the antitrust laws will enable customers to feel confident that the price they are being quoted is the product of a fair marketplace.

The lack of affordable health insurance plagues families throughout our country, and this amendment is a first step towards ensuring that health insurers and medical malpractice insurers are subject to fair competition. I hope all Senators will join me in support of this important amendment.

Madam President, I note my amendment removes the outdated, antiquated, unnecessary antitrust protection given to our insurance companies, a protection which, instead of allowing them to thrive and give us lower premiums, has perversely acted in such a way that our premiums continue to rise 15 percent in the last year alone. This will help change that.

EXECUTIVE SESSION

NOMINATION OF JACQUELINE H. NGUYEN TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to report the following nomination.

The bill clerk read the nomination of Jacqueline H. Nguyen, of California, to be United States District Judge for the Central District of California.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. LEAHY. Madam President, I understand the Senator from California desires some time. I yield her 5 minutes, beginning now.

Mrs. FEINSTEIN. Madam President, I rise to speak in support of the nomination of California Superior Court Judge Jacqueline Nguyen to be a Federal District Court Judge from the Central District of California. I urge her confirmation.

Judge Nguyen is a tested judge with a track record of success as both a judge and a Federal prosecutor. She will be the first Vietnamese American on the Federal bench. Her nomination comes about this way.

I have had, for a long time, a bipartisan judicial selection committee in California to advise me in recommending judicial nominees to the President. The committee gave Judge Nguyen its unanimous recommendation. Then I recommended her to the President for his nomination to the Federal district court. I believe she is going to be an excellent Federal district court judge in the Central District.

Judge Nguyen was born in South Vietnam. She immigrated to this country with her family at the age of 10 during the final days of the Vietnam war. The Nguyens spent several months living in a refugee camp in Camp Pendleton, San Diego, before moving to the La Crescenta neighborhood of Los Angeles. She was naturalized in 1984.

Judge Nguyen's parents worked two and three jobs at a time in Los Angeles, and Judge Nguyen and her siblings worked side by side with them, cleaning a dental office, peeling and cutting apples for a pie company, and finally managing the doughnut shop that their parents bought and owned.

In her application to my selection committee, she explained that looking back on these experiences she realizes now that they were difficult. She wrote:

> But I nevertheless feel incredibly fortunate because those early years gave me invaluable life lessons that have shaped who I am today.

She went on to graduate from Occidental College in 1987 and from UCLA Law School in 1991. She was in the Moot Court Honors Program.

For the first 4 years of her career, she practiced commercial law as a litigation associate at the private law firm of Musick, Peeler and Garrett, where her caseload included complex contract disputes and intellectual property cases. In 1995 she left the firm to become an assistant U.S. attorney in the U.S. Attorney's Office in Los Angeles, and a very good one.

As an assistant U.S. attorney in the criminal division, she prosecuted a wide variety of crimes, including violent crimes, narcotics trafficking, organized crime, gun cases, and all kinds of fraud. She spent 6 months in the organized crime strike force section, handling a title III wiretap investigation of a Russian organized crime group responsible for smuggling sex slaves into the United States from the Ukraine. In 2000, she received a special commendation from FBI Director Louis Freeh for obtaining the first conviction ever in the United States against a defendant for providing material support to a designated terrorist organization.

The Justice Department recognized her with three additional rewards for superior performance as an assistant U.S. attorney, and in 2000 she was promoted to deputy chief of the general crimes section.

In 2002, Judge Nguyen left the U.S. attorney's office when Governor Gray Davis appointed her to the Superior Court in Los Angeles, and she has been on that bench for more than 7 years and has presided over more than 65 jury trials.

As she has said in her own words:

> I am deeply passionate about the privileges that we enjoy as Americans and am committed to spending my life in public service. If I am given the honor to serve as a United States District Judge, I believe my experiences, work ethic, maturity and judgment will serve me well.

I could not agree more. I think Judge Nguyen will be a truly outstanding judge of the Federal district court and I urge my colleagues to support her nomination.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. LEAHY. Madam President, I absolutely concur with the comments of the distinguished senior Senator from California in support of the nomination of Judge Jacqueline Nguyen to serve on the Federal Court in the Central District of California. I supported Judge Nguyen in the committee and I am glad we are able to act on her nomination today.

Judge Nguyen participated in a confirmation hearing before the Judiciary Committee on September 23. Hers was a historic hearing at which, for the first time, three Asian Pacific American judicial nominees appeared together—Judge Nguyen, Dolly Gee and Judge Edward Chen. Indeed, three Asian Pacific American judicial nominees have never been confirmed in the same year. Of the 876 active judges serving on our Federal courts, only 8 are Asian Pacific American.

We also held a November hearing for Judge Denny Chin, a well-respected judge on the Southern District of New York, whom President Obama has nominated for elevation to the Second Circuit Court of Appeals. Judge Chin was the first Asian Pacific American appointed as a Federal district court judge outside the Ninth Circuit. If confirmed to the Second Circuit, he will be the only active Asian Pacific American judge to serve on a Federal appellate court anywhere in the country. It is unbelievable that with 179 Federal appellate court judgeships in our country, none are currently held by an Asian Pacific American. More than 14

years have passed since an Asian Pacific American was nominated to a Federal appellate court. This progress is long overdue.

I commend President Obama for following his commitment to nominate men and women to the Federal bench who reflect the diversity of America. Diversity on the bench helps ensure that the words ''equal justice under law,'' inscribed in Vermont marble over the entrance to the Supreme Court are a reality, and that justice is rendered fairly and impartially.

Judge Jacqueline Nguyen will be the first Vietnamese American to serve as a Federal district court judge in the United States, and the first Asian Pacific American woman to serve as a Federal district court judge in the State of California. Today is an important milestone not only for Judge Nguyen, the Vietnamese American community and the Asian Pacific American community, but for all Americans.

Judge Nguyen, Ms. Gee, and Judge Chen were reported favorably to the Senate on October 15, more than 6 weeks ago. I am glad we are proceeding with Judge Nguyen but urge Senate Republicans to allow the other nominations to proceed to Senate debate and votes, as well. When she is confirmed, Ms. Gee will be the first female Chinese American Federal district court judge in the Nation. When he is confirmed, Judge Chen will be the first Asian Pacific American Federal district court judge in the history of the Northern District of California. Judge Chen is already the first Asian Pacific American to serve in that district as a magistrate judge. The American Bar Association's Standing Committee on the Federal Judiciary has rated the three of them unanimously as ''well qualified,'' their highest rating.

I thank the committee's ranking member, Senator SESSIONS, for his cooperation in securing the recent confirmations of Judge Christina Reiss of Vermont and Judge Abdul Kallon of Alabama before the Thanksgiving recess. They were confirmed 17 days after their hearing. That prompt action by the Senate demonstrates what we can do when we work in good faith. It should not take weeks for the Judiciary Committee to report nominations and additional weeks and months before Senate Republicans allow nominations to be considered by the Senate. We have shown what we can do.

Following the model we have established for Judges Reiss and Kallon, the Senate should be able to consider and confirm all eight of the judicial nominations currently on the Executive Calendar awaiting final action by the Senate, the additional five judicial nominees included at confirmation hearings in November, and Justice Thompson of Rhode Island, who had her hearing this morning. Acting on these nominations, we can reach a total of 23 Federal circuit and district court confirmations this year. That is well short of the total of 28 a Democratic Senate majority worked to confirm in President Bush's first year in office, 2001, but better than the 9 confirmations achieved in the first 11 months of this year.

This year we have witnessed unprecedented delays in the consideration of qualified and noncontroversial nominations. We have had to waste weeks seeking time agreements in order to consider nominations that were then confirmed unanimously. We have seen nominees strongly supported by their home state Senators, both Republican and Democratic, delayed for months and unsuccessfully filibustered. I have been concerned that these actions by the Republican leadership signal their return to their practices in the 1990s, which resulted in more than doubling circuit court vacancies and led to the pocket filibuster of more than 60 of President Clinton's nominees. The crisis they created eventually led to public criticism of their actions by Chief Justice Rehnquist during those years.

I hope that instead of withholding consent and threatening filibusters of President Obama's judicial nominees, Senate Republicans will treat the nominees of President Obama fairly. I made sure that we treated President Bush's nominees more fairly than President Clinton's nominees had been treated. In the 17 months that I served as chairman of this Committee during President Bush's first term, the Senate confirmed 100 of his judicial nominations. We should continue that progress, but need Republican cooperation to do so. I urge them to turn away from their partisanship and begin to work with the President and the Senate majority leader.

During the month of December in 2001, a Democratic-led Senate confirmed 10 of President Bush's judicial nominees, bringing the total number of nominations confirmed that year to 28. We will have to exceed that number this month in order to get to 20 confirmations, and a possible total of 23 this year. I fear that Senate Republican delaying tactics will, instead, yield the lowest total in modern history. If Senate Republicans continue their delaying tactics, the total could be as low as that during the 1996 session when a Republican Senate majority would only allow 17 judicial confirmations all session, including none for circuit courts.

Today, with the confirmation of Judge Nguyen, we will finally move into double digits in the confirmations of Federal circuit and district court judges—hers is our 10th this year. Although there have been nearly 110 judicial vacancies this year on our Federal circuit and district courts around the country, only 10 vacancies have been filled. That is wrong. The American people deserve better.

It has not been for lack of qualified nominees. As I have noted, there are seven more nominations awaiting Senate action on the Senate Executive Calendar and another six who have had their confirmation hearings and can be considered once approved by the Judiciary Committee. The Senate should do better and could if Senate Republicans would remove their holds and stop the delaying tactics.

During President Bush's last year in office, we reduced judicial vacancies to as low as 34, even though it was a presidential election year. Judicial vacancies have now spiked. There are currently 98 vacancies on our Federal circuit and district courts, and 23 more have already been announced. This is approaching record levels. I know we can do better. Justice should not be delayed or denied to any American because of overburdened courts and the lack of Federal judges.

Mr. LEAHY. Madam President, have the yeas and nays been requested on this nomination?

The PRESIDING OFFICER. They have not.

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

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is, Will the Senate advise and consent to the nomination of Jacqueline H. Nguyen, of California, to be U.S. district judge for the Central District of California?

The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. DURBIN. I announce that the Senator from Alaska (Mr. BEGICH) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Alabama (Mr. SESSIONS).

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

The result was announced—yeas 97, nays 0, as follows:

[Rollcall Vote No. 354 Ex.]

YEAS—97

Akaka	Ensign	Lugar
Alexander	Enzi	McCain
Barrasso	Feingold	McCaskill
Baucus	Feinstein	McConnell
Bayh	Franken	Menendez
Bennet	Gillibrand	Merkley
Bennett	Graham	Mikulski
Bingaman	Grassley	Murkowski
Bond	Gregg	Murray
Boxer	Hagan	Nelson (NE)
Brown	Harkin	Nelson (FL)
Brownback	Hatch	Pryor
Bunning	Hutchison	Reed
Burr	Inhofe	Reid
Burris	Inouye	Risch
Cantwell	Isakson	Roberts
Cardin	Johanns	Rockefeller
Carper	Johnson	Sanders
Casey	Kaufman	Schumer
Chambliss	Kerry	Shaheen
Coburn	Kirk	Shelby
Cochran	Klobuchar	Snowe
Collins	Kohl	Specter
Conrad	Kyl	Stabenow
Corker	Landrieu	Tester
Cornyn	Lautenberg	Thune
Crapo	Leahy	Udall (CO)
DeMint	LeMieux	Udall (NM)
Dodd	Levin	Vitter
Dorgan	Lieberman	
Durbin	Lincoln	

Voinovich	Webb	Wicker
Warner	Whitehouse	Wyden

NOT VOTING—3

Begich	Byrd	Sessions

The nomination was confirmed.

The PRESIDING OFFICER. Under the previous order, the motion to reconsider is considered made and laid upon the table.

The President will be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate will stand in recess until 2:15 p.m.

Thereupon, the Senate, at 12:33 p.m., recessed and reassembled at 2:15 p.m. when called to order by the Presiding Officer (Mr. CARPER).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—Resumed

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, as I said yesterday when I spoke on this very same bill, the excesses of the Reid bill appear willfully ignorant of what is going on in the rest of the economy outside of health care.

I believe the reason people have objected to the health care bill so quickly after the summer was that there was a rude awakening on a lot of other things the Congress has done to put this country further into debt, and then they heard us talking about $1.3 trillion and $1.6 trillion for health care, and they thought Congress had gone bananas. So everything seemed to focus on health care reform at that particular time. People were concerned about the economy as a whole. I think the health care issue in and of itself was what people came out for, but health care was kind of the straw that broke the camel's back and brought attention to everything else—the debt and things that weren't working. At the same time, they saw the auto industry going into bankruptcy and, of course, being bailed out or nationalized, as it is. They have seen banks go under. Then they wondered about health care being nationalized as well.

We have seen our Federal debt skyrocket by $1.4 trillion since this President took office. I say ''since this President took office'' because I acknowledge there was a trillion-dollar debt in last year's budget. Just with the addition, it comes out to $11,500 per household. So our Federal debt exceeds $12 trillion for the first time in history. Already, foreign holdings of U.S. Treasuries stand at nearly $3.5 trillion or 46 percent of the Federal debt held by the public. There doesn't appear to be light at the end of the tunnel. Don't just take my word for it. We have the nonpartisan CBO and the White House Office of Management and Budget which have intellectually honest people working there who aren't politically motivated who tell us really what is what. This is what they have to say. Both have stated that within 5 years, the Obama administration's policies will more than double the amount of debt held by the public. Both have stated that by 2019 these policies will more than triple the national debt.

In this context, you would expect Congress to be considering a bill that would create jobs and prevent the country from being burdened with a bigger and more unsustainable Federal budget. Instead of working to bring the Federal budget under control, we have in this Congress—the majority of it, by 60 being Democratic—putting forward a bill, this 2,074-page bill before us that will cost $2.5 trillion when fully implemented. Instead of addressing the budget crisis, this bill will bend the Federal spending curve the wrong way by over $160 billion over the next 10 years.

I remember during the summer that the Gang of 6, under the leadership of Senator BAUCUS—I was part of that bipartisan group—said there are two things we need to accomplish: We need to make sure that what we have comes out balanced, and we also need to make sure we do not have inflation of health care continuing to go up, that we would eventually bring it down. These bills don't do either. I know people say we do have the 10-year window balance. Yes, that is technically right. But when you have 10 years of income and 6 years of policy expenditure, it is easy to do almost anything you want to in that 10-year window. But you have to look beyond that 10-year window, and then you have questions about that.

So instead of addressing this budget crisis, this bill adds to the Federal burden with enormous costs from the biggest Medicaid expansion in history and unfunded liabilities from the new program. Instead of addressing this budget crisis, we are now considering this 2,074-page bill that cuts Medicare by $½ trillion and threatens seniors' access to care.

After the bailouts of Wall Street and Detroit, a stimulus bill that has led to the highest unemployment in 26 years, and the Federal Reserve System shoveling money out the door without any accountability—they even object to having the GAO check on them—the health care reform agenda the Democratic leadership put forward is, once again, kind of the straw that broke the camel's back.

We have the Senator from Arizona offering a motion to send this bill back to the Finance Committee with instructions to report a bill without the drastic, arbitrary Medicare cuts that are in this bill. I support the Senator's motion because it is an opportunity to fix the bill and then come back to the full Senate with a better bill. Anything that comes back to the Senate floor should not have the drastic and arbitrary Medicare cuts.

I am hearing this from seniors: I have paid into this Medicare for all these years. I am in retirement, and now Congress wants to take that money and establish a new entitlement program for somebody else other than seniors. So to a lot of seniors it just doesn't add up.

This bill, as written, now permanently cuts all annual Medicare provider payment updates in order to account for the supposed increases in productivity by health care providers. The productivity measure used to cut provider payments in this bill does not represent productivity for a specific type of provider, such as nursing homes.

You would think that if Medicare is going to reduce your payments to account for increases in productivity, it would at least measure your productivity, not an entire group of productivity or not somebody else's productivity but yours, and you would be rewarded according to that productivity or, if it wasn't productive, be harmed because of it because you are not doing the best job you can. But that is not the case. Instead, these reform bills would make the payment cuts based on measures of productivity for the entire economy. So if the productivity of the economy grows because computer chips and other products are made more efficiently, then health care providers see their payments go down. What is the relationship? These permanent cuts threaten beneficiary access to care.

The Chief Actuary at the U.S. Department of Health and Human Services recently identified this threat to beneficiary access to care. He confirmed this in an October 21 memorandum analyzing the House of Representatives' bill and again in a November 13 memorandum. Both the House bill and the Senate bill propose the same type of permanent Medicare productivity cuts.

We have a chart here. Here is what Medicare's own Chief Actuary had to say about these productivity cuts. Referring to these cuts, he wrote:

> The estimated savings . . . may be unrealistic.

In their analysis of these provisions, Medicare's own Chief Actuary said:

> It is doubtful that many could improve their own productivity to the degree achieved by the economy at large.

The Actuary goes on to say:

> We are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy.

So you have a $14 trillion economy today. You have $2.3 trillion of that, or one-sixth, related to health care, and you are going to try to do something to the health care aspect, productivity measure, harm or benefit, based upon what happens to the entire $14 trillion economy? That doesn't make sense.

The Chief Actuary's conclusion is that it would be difficult for providers to even remain profitable over time as Medicare payments fail to keep up with the cost of caring for the beneficiaries.

Going back to my chart again, ultimately here is the Chief Actuary's conclusion—that providers who rely on Medicare might end their participation in Medicare, ''possibly jeopardizing access to care for beneficiaries.''

This bill also cuts $120 billion from the Medicare Advantage Program, which provides health coverage to 11 million seniors, including the 64,000 seniors in my State of Iowa. These drastic Medicare cuts would reduce Medicare payments for those 11 million beneficiaries by close to 50 percent.

Just like a lot of people, seniors are struggling financially right now, and these Medicare Advantage cuts will only make it harder for them to afford vision care, chronic-care management, dental care, and other benefits they have come to rely on, of their own choosing, because they decided to go to Medicare Advantage instead of staying in traditional Medicare. And what they are going to lose if they don't want to stay in Medicare Advantage and they are not going to get the benefits they got out of it, they go over to traditional Medicare, are these sorts of benefits which will not be included in traditional Medicare.

During the campaign, the President said that if you like what you have, you can keep it. Well, that won't be true for Medicare Advantage people. They will either pay more, which is contrary to what the President said in his September speech to the joint session of Congress, they are going to pay more or lose benefits.

Another problem is that this bill creates a new body of unelected officials with broad authority to make even further cuts in Medicare. Ironically, this body has been renamed the ''Independent Medicare Advisory Board,'' but it is not really advisory. I would hardly describe this group that way when its so-called recommendations can automatically go into effect, even absent congressional action—absent Congress going after it.

I want to go to the chart again. The Wall Street Journal has a more appropriate name for this group. They call it the ''rationing commission.'' They described it as ''the unelected body that will dictate future medical decisions.''

These additional cuts in Medicare will be driven by arbitrary spending targets and automatic Medicare cuts written into law by this bill.

This bill, unwisely, makes this board permanent. This bill requires this board to continue making even more cuts to Medicare and to do that forever. If you want to stop it, it will take another act of Congress to do it. Of course, this kind of sounds like the sustainable growth rate, or SGR, that impacts doctors every year. We always have to correct the mistakes that were made by passing the sustainable growth rate, SGR, first set in place probably 20 years ago, because this SGR formula set arbitrary spending targets. These targets turned out to be unrealistic. Now that flawed formula will cause an automatic 21-percent cut in Medicare physician payments on January 1 if Congress doesn't intervene by the end of the year.

We all know the challenges Congress faces every year in trying to prevent these Medicare physician cuts that are supposed to take place because spending targets have been exceeded, so automatic payment cuts are then to automatically kick in.

We have all heard from physicians in our States about the challenges in providing care to Medicare beneficiaries while these payment cuts loom above. This permanent board would cause the same problem for the entire Medicare Program, not just as SGR does for physician payments. This is a far bigger threat to the Medicare Program. It will jeopardize access to health care for our Nation's seniors on a much bigger scale.

If this bill is enacted with this permanent board, we will be hearing from other providers, in addition to doctors, about how they cannot afford to treat Medicare patients.

What is more alarming is that special back-room deals were cut to exempt some providers. This forces then, because of these special exemptions that were made, even greater cuts to fall directly on the remaining providers.

Also, the Congressional Budget Office has confirmed that the board structure requires it to take focus on its Budget Act on premiums that seniors pay for Part D prescription drug coverage and for Medicare Advantage.

I have already spoken about Medicare Advantage but just think: One of the things we hear about this time of the year all the time from seniors is prescription drug costs are going up, premiums on Part D are going up. Then you want to give this advisory commission—that is not advisory—authority to increase premiums that seniors pay for Part D prescription drug coverage? That means higher premiums for some of our most vulnerable populations.

Another issue that cannot be ignored is the pending insolvency of the Medicare Program. The Medicare hospital insurance fund started going broke last year. That means more money is going out than is coming in from the payroll tax. The Medicare trustees—you remember, they report yearly and they look ahead 75 years—the Medicare trustees have been warning all of us for years that this trust fund is in terrible trouble and, by a certain date, 2017, we bust it. But rather than work to bridge Medicare's $37 trillion in unfunded liabilities—and that $37 trillion is that 75-year figure the trustees give us once a year, each spring, as they update it—so instead of working to bridge that $37 trillion of unfunded liabilities, this bill does what? It cuts $½ trillion from the Medicare Program to fund yet another unsustainable health care entitlement program.

Medicare has a major problem with physician payments that could cost more than $250 billion to fix, but this bill ignores the problem. Instead, the proposed legislation assumes the government would implement the 23-percent Medicare cut scheduled to go against doctors in January 2011, as well as additional cuts that are scheduled for future years under that SGR.

By pretending the physician payment issue does not exist, this bill would leave future Congresses virtually no way to restructure Medicare that would fix this problem. Instead, this bill diverts Medicare resources elsewhere and ignores major problems such as that one.

Besides ignoring major problems, such as the physician payment issue, this bill also ignores the predictions of experts that Medicare cuts, such as are in this bill, will jeopardize access to care of Medicare beneficiaries.

There are no fail-safes in this bill that would automatically kick in if these drastic cuts caused limited provider access or worsened quality of care. Instead, Congress would have to step in. Congress can always step in, but will it step in. We know how impossible it is to undo this kind of damage. By making this board a permanent program and requiring permanent productivity cuts, they become part of the baseline in the next decade. They go on cutting, cutting, cutting forever. If Congress ever wants to shut off those cuts, then this is the problem Congress faces: We have to come up with offsets to do it. The administration can cut and cut and cut or add and add and add. They do not have to do that. But the budget laws require us to have these offsets or to do the famously impossible thing to do—get a 60-vote margin to overcome it.

The Congressional Budget Office has projected that these Medicare cuts keep increasing by 10 to 15 percent each year over the next decade. You heard me right. Medicare cuts keep growing 10 to 15 percent each year beyond the year 2019. Those are some pretty substantial cuts in a program that 43 million seniors and people with disabilities rely on for their health coverage.

Provisions, such as the productivity adjustments and the Medicare independent advisory board, would drive the increased cuts to the program. This gives us an idea of the damage these bills will do to health care. This is an example of the challenge Congress will face in the next decade if this bill—this 2,074-page bill—becomes law.

The few years of extended life this bill would give to the Medicare hospital insurance trust fund is a pyrrhic victory because the drastic and permanent Medicare cuts in this bill will worsen health care quality and access.

This bill is the wrong way to address a big and unsustainable budget. You

simply cannot slash Medicare payments, spend those funds to start up another new unsustainable government entitlement program, and then turn a blind eye toward the effect on access and quality. That is why I will support the motion of the Senator from Arizona to commit this bill and develop a bill without these Medicare cuts. I urge my colleagues to do the same.

The reason I urge my colleagues to do the same is because we have an opportunity to step back just a little ways, go back to the drawing board on bipartisanship and maybe come up with something that fits in with the health care issues affecting the lives of 306 million Americans and, secondly, restructuring one-sixth of our economy. That is something I have heard people on both sides of the aisle say ought to be done on more of a consensus basis than the partisan road this is going down. It was a road that, for the first 6 months of this year, looked very doable, but it never turned out that way.

I get back to this bottom line: If you are having a coffee club meeting in some restaurant Saturday morning in Delaware, Illinois or Iowa, and they are talking about health care reform and I go in to explain that what we are discussing right now on the floor of the Senate is going to raise taxes, it is going to raise premiums, it is going to not do anything about the inflation of health care costs, and we are going to take almost $½ trillion out of the Medicare fund to fund a new entitlement program, I would say that unanimously people would say: This is not health care reform. There has to be something else. But we throw away the word ''reform'' when we are not accomplishing the kind of goals we set out to accomplish the first 6 months of this year.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, there is a saying in Iowa; that is, that any old mule can kick down a barn door, but it takes a carpenter to build one. I would modify that slightly and say any old elephant can kick down a barn door, but it takes a carpenter to build one.

We are debating health care reform. The American people are following us closely because it affects every single one of us in this room, everyone in the galleries, and everyone watching. This is one of the few issues we will debate which you can bet is going to affect you and your family personally. It is rare that an issue comes before us of this gravity and an issue that reaches every single person in America. It may be the biggest single issue we have ever tackled on the floor of the Senate in terms of its scope and its impact on the future of every single one of us.

For more than a year, a lot of people have been working hard to come up with a piece of legislation that will have a positive impact on health care in America. It has involved lengthy committee hearings. The Presiding Officer is a member of the Senate Finance Committee. They sat in meetings hour after weary hour, day after weary day, considering amendments before they produced a bill that is part of what we have before us today.

The Senator from Iowa is part of that same committee. I understand he met personally over 60 times with Democratic Senators and a few from his own side trying to see if we could come up with some kind of bipartisan approach. I commend him for his good-faith effort in doing that.

There is another committee, the Health, Education, Labor, and Pensions Committee, that spent even more days in deliberation on a bill, considered over 100 different amendments, adopted over 100 Republican amendments to the bill, and not one single Republican Senator would then vote for the bill—not one. One Senator, Senator SNOWE of Maine, voted for the Senate Finance Committee bill. One Republican Senator voted for that version of the bill.

What we have today—and I wish to slightly modify the remarks of my friend from Iowa—is a 2,074-page bill with a 1-page add. This is Senator REID's amendment to use it as a substitute. So it is 2,075 pages, created by these two committees in the Senate and a similar endeavor taking place in the House.

For at least 10 days, this bill, in its entirety, has been available for public review. I ask anyone interested who wants to read this bill, as every Member should, to go to the Senate Democratic Web site. If you Google ''Senate Democrats,'' you will find it and you will find this bill in its entirety, every single word of it, sitting out there to be read and reviewed, as it should be.

Then I invite you, for comparison's sake, to go to the Senate Republican Web site to look at the bill produced by the Senate Republican side. Take a look at the Senate Republican health care reform bill. Take a look at what they propose to change—the health care system in America. Look at the Senate Republican proposals for making health insurance more affordable. Look at the Senate Republican proposals for dealing with health insurance companies which deny you coverage because of preexisting conditions. Take a look at the Senate Republican approach to pass health care reform and not add to the deficit. I am afraid you will be disappointed because, as the Senator from Iowa knows, when you go to the Senate Republican Web site, there is no Senate Republican bill. In fact, what you will find on the Senate Republican Web site is the Democratic bill.

For more than a year, while we have labored to produce this monumental, historic legislation, our Republican colleagues on the other side of the aisle have not broken a sweat to produce their own answer to this challenge facing America. All they can do is come before us and criticize this bill. Any old mule can kick down a barn door, but it takes a carpenter to build one.

We have been working for over a year—almost a year—to build this health care reform package. Here is what we know. We just received a report from the Congressional Budget Office, which is akin to the referee up here. This is an agency that takes a look at what we do and tells us whether it is going to reduce the deficit, add to the deficit, reach its stated goal or fail to reach it. It is maddening sometimes to have this separate agency kind of looking over your shoulder, but they do. They reported just yesterday that this bill will make health insurance more affordable for many Americans and will not add to the costs for many others.

I wish it would do more. I wish it would bring down costs dramatically, even more. But for weeks and months we have heard from the Republican side that our health care reform proposal would run premiums sky high. It turns out they were wrong. This bill we have produced moves us toward more affordable health insurance. Every American who pays any attention to the cost of health insurance knows that is absolutely essential. In the last 10 years, health insurance premiums have gone up 131 percent in America. Ten years ago, a family could have bought health insurance for about $6,000 a year. Now they buy it on average for about $12,000 a year. In 7 or 8 years it will go up to $24,000 a year in premiums, projecting it will eat up 40 percent of your income for health insurance in just 8 or 10 years.

That is an impossible situation. We know it is. It is unsustainable. Businesses can't offer health insurance that expensive. Individuals can't buy health insurance that expensive. So if we do nothing we will reach a situation where the current health care system in America will start to collapse. I do not want to stand idly by and let that happen; neither does President Obama. He has challenged us to address it and address it honestly.

On the other side of the aisle, the Senate Republicans have not produced a bill, a proposal, an alternative which will make health insurance more affordable—nothing. They come before us in criticism of what we have done, and yet they cannot produce a bill.

I might also tell you the same Congressional Budget Office tells us the bill we put together will actually reduce the Federal deficit over the next 10 years by at least $130 billion. This bill, this 2,075-page bill, will cut more deficit than any piece of legislation we have ever enacted in Congress.

The Senator from Iowa is concerned about our national debt. So am I. Where is the Senate Republican proposal for health care reform that is going to reduce America's deficit? Incidentally, the same Congressional Budget Office says in the second 10 years—

think that far in advance—this approach will reduce the Federal deficit by another $650 billion.

I ask the Senator from Iowa, with all his concern about the Federal deficit, where is the Senate Republican bill that will reduce the Federal deficit by $750 billion over 20 years?

The answer, I am sorry to tell you, is it does not exist. They either have not or cannot write a bill. They are legislators, but frankly they have come here to be critical of what we have done and will not offer a substitute or an alternative.

There is something else this bill does. It is a travesty in America today that almost 50 million people do not have health insurance. A lot of these folks are children. A lot of them are people in low-wage jobs with no benefits. A lot of them are the newly unemployed. These are 50 million of our neighbors in America who go to sleep at night without the peace of mind of having health insurance protection.

In my life it happened once: newly married, college student, baby on the way, no health insurance, and our baby had a problem. I ended up carrying, for 8 years, medical bills that I slowly paid off year after year. That goes back many years ago, as you might imagine, but it was troubling and heartbreaking to be the father of a child and not have health insurance; to sit at Children's Memorial Hospital in Washington, in the room that was set aside for people without health insurance, and wait until my number was called to bring my wife and my baby in for a checkup. I didn't have health insurance. I never felt more helpless in my life.

Fifty million Americans go to bed each night with that feeling. They don't have health insurance. What does this bill, this 2,075-page bill, do about it? It extends the coverage of health insurance, the peace of mind and protection of health insurance to 94 percent of Americans. It is the largest extension of health insurance in our history.

Where is the Republican alternative that offers coverage for 94 percent of Americans? It doesn't exist. They have not written that bill. They don't know how to write that bill. They do know how to come and criticize this bill, but they cannot produce a bill which covers 94 percent of Americans and provides tax credits and tax assistance to help those Americans pay their premiums.

If you are making under poverty wages, let's say you are making less than $14,000 a year—and I have friends of mine in my State who are—you are covered by Medicaid. You don't pay premiums. The Federal Government compensates the States and pays the premiums. All the way up to about $80,000 for a family of four, we provide credits and help to pay the premiums, as we should, because premiums can break the bank not only for businesses but for families.

There is also something we do in this bill I never hear from the other side of the aisle—and I will tell you why in just a second. We give consumers across America a fighting chance when the health insurance company goes to war with you. Do you know what I am talking about? If somebody in your family gets sick, you know it is going to require a hospitalization or surgery and you know the cost is going to go sky high, and you say: Thank goodness, I have health insurance. You make the claim and the health insurance company comes back and says: We dispute the claim. We are not paying. People say: Wait a minute, I have been paying health insurance premiums for years just for this day, and you are telling me I don't have coverage?

It happens thousands and thousands of times each day. Do you know why? Health insurance companies are profitable when they say no. What are the reasons for saying no? ''You failed to disclose a preexisting condition when you applied for the insurance.'' It turns out they go to ridiculous extremes to find an excuse not to provide coverage.

We also know what happens when you lose a job. You can't take your insurance with you, by and large. We know when your child reaches the age of 24 they are no longer carried on your family health insurance. Those are the realities of health insurance companies saying no. I have yet to hear the first Republican Senator come to the floor and say that is outrageous and it has to change. We have to tackle the health insurance industry because the health insurance industry opposes this bill.

The health insurance industry believes their profitability and their future depend on saying no. This bill starts saying to these companies: You can't say no based on a preexisting condition, based on lifetime limit, based on losing a job. And we cover kids through the age of 26. We extend the family coverage to children of that age, and you know that is only sensible because a lot of kids are going to college and getting out without jobs. You want them covered by your family health insurance plan. This bill does it.

Republicans have yet to produce one bill, just one, on health care reform to take on the health insurance industry. Instead, what they have come to do, and the pending amendment by the Senator from Arizona leads with this, is to protect the health insurance companies. The first thing the motion to commit does, from the Senator from Arizona, is to instruct the committee, the Senate Finance Committee, to protect a program called Medicare Advantage.

This is a great idea for health insurance companies and not a great idea for most seniors or taxpayers in America. Allow me to explain. The health insurance companies came to us several years ago and said Medicare is a bureaucratic mess. The government cannot run these programs. We are in the private sector. We understand competition. Let us compete with Medicare.

They were given the right to do that. Private health insurance companies were given the right to write health insurance that provides Medicare benefits. They said they could do it more cheaply and, in fact, some of them did. But at the end of the day, after years of watching them, it turned out these Medicare Advantage policies cost 14 percent more—not less, 14 percent more—than government-administered Medicare Programs. In other words, we were subsidizing health insurance companies, paying them more for the same Medicare coverage people already had received.

They loved it. Thousands and thousands of Americans are now covered by Medicare Advantage with these great subsidies coming from the Federal Government. Talk about an earmark, Senator, 14 percent—what an earmark that is, a subsidy given to the private health insurance companies.

Mr. MCCAIN. Will the Senator yield for a question? Since the Senator mentioned my name, will he yield for a question?

Mr. DURBIN. What the basic problem with the amendment of the Senator form Arizona is—and I will yield in just a moment—what the basic problem with his amendment is, he is protecting these health insurance companies with Medicare Advantage. First thing he does. He is protecting this subsidy, this big fat earmark we put in legislation, 14 percent bump in premiums is protected by this motion to commit.

It is understandable the health insurance companies want to keep this. It is a sweet deal. They are getting paid for something they promised us would never happen. Also, there is a provision in the motion to commit of the Senator that says we should take out the conflict-of-interest sections in Medicare. Do you know what that is? That is when your doctor also owns the laboratory which does your blood test and the imaging center which does the x rays and says: I am not sure what is wrong with you, but I know there are two things you need: You need a blood test and you need an x ray.

Maybe you do; maybe you don't. We say in this bill you have to disclose to your patient that you have a personal financial interest in this laboratory and this processing operation, and you have to give them an alternative to shop for another place if they want. Is that unreasonable? It is one of the provisions the Senator from Arizona wants to take out. It is a savings in Medicare.

That is unfortunate. We have to do our best to eliminate the waste and fraud and abuse, as terrible as that old cliche is, in Medicare. Why is it that the same medical procedure offered in Rochester, MN, to a Medicare recipient costs twice as much or more in Miami, FL? Do you think maybe we ought to take a look at that? I think we should. I think maybe there is some price gouging. I want to know.

Does that mean we are going to reduce the benefits for someone living in Miami? Not necessarily. But it means the taxpayers will not be ripped off. Medicare would not go broke. We are doing what we need to do to be responsible. So taking money out of Medicare means shutting off the subsidy to the private health insurance companies for Medicare Advantage. It means stopping the self-dealing of some doctors who are sending Medicare patients to their own labs and their own processing companies. It means finding out where the waste is taking place.

The Senator from Arizona says we instruct the Finance Committee to take out those provisions in the bill. Keep Medicare Advantage there, with the 14 percent subsidy for private health insurance companies, don't engage these doctors when it comes to these conflicts of interest. I don't think that is right.

It was not long ago that my friend from Arizona was a candidate for another office. During the course of his campaign for President, he suggested we have a pretty substantial cut in Medicare and Medicaid. In fact, during the campaign the Senator from Arizona called for $1.3 trillion in reforms in Medicare and Medicaid, more than twice as much as we are calling for in Medicare, 2½ times as much.

Douglas Holtz-Eakin, who worked for the Senator from Arizona, said the campaign planned to fund tax credits in their health care proposals with savings from Medicare and Medicaid. So the idea of saving money in Medicare is certainly not something with which the Senator is unfamiliar. We all understand there are possibilities for savings that don't jeopardize basic services for seniors. We also understand that left untouched, Medicare is going broke. Ignoring the problem will make it worse. If we want to put Medicare on sound footing we have to tackle this issue foursquare. We cannot afford these subsidies for private health care companies for Medicare Advantage, and we cannot afford the waste that is going on in the system today.

I might also tell you the increase in payroll taxes for those individuals making over $200,000 a year and families over $250,000 a year—that is the increase in the Medicare tax—is going to be buying 5 years of solvency for Medicare. So when they talk about our raising taxes—true, at the highest income levels—what they don't tell you is the other side of the coin. The money brought in goes straight to the Medicare trust fund to keep it solid.

What else does this bill do? It starts filling the doughnut hole. You may not know what that means until you happen to be a senior or have one in your family, but Medicare prescription drug coverage stops paying at a certain point. This bill starts coverage in the doughnut hole, in the gap in coverage that currently exists in Medicare prescription Part D.

Where is the Republican bill to fill the doughnut hole? It doesn't exist—at least I have not seen it. It is not on their Web site. Here is ours. That is why AARP has endorsed this bill. The American Association of Retired Persons knows this bill is a good bill for seniors.

I urge my colleagues to oppose the McCain motion to commit.

If we take this bill off the floor, which many Republicans want us to do, it will take us days, maybe a week, to bring it back to the floor. They want to delay this as long as possible. They want us to fail. They want us to stop. They want us to adopt the Senate Republican approach to health care reform which is do nothing, leave the system the way it is. We cannot continue the system the way it is. This is a responsible bill. It makes health insurance affordable. It reduces the deficit, according to the CBO, and covers 94 percent of Americans. It finally tackles the health insurance companies for the first time in a long time, and it buys at least 5 years more for the Medicare Program. I wish I could compare it to the Senate Republican approach, but that doesn't exist. Any mule can kick down a barn door. It takes a carpenter to build one.

I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from Arizona.

Mr. MCCAIN. I regret that the Senator from Illinois did not observe the courtesies of the Senate, particularly when a person's name is mentioned, as he continued to mention my name throughout and totally falsifying my position both in the Presidential campaign and the position that we have on this side and this amendment. I have always extended that courtesy to the Senator from Illinois. I deeply regret that even this comity of the Senate is no longer observed.

I say to the Senator from Illinois, I regret you would not respond to a question I had posed, when you had said: I will respond in a minute. Again, even comity is not observed here.

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

Mr. MCCAIN. I will go ahead with the—the Senator did not provide me with the courtesy of allowing me to respond to a question. Now you want me to respond to a question from you? I will display more courtesy than you displayed to me. Go ahead.

Mr. DURBIN. I apologize. I planned on yielding to you. I would be happy to yield to you. I always do, and I failed to. I apologize.

Mr. MCCAIN. Well, I guess my questions were, one, did the Senator, who claimed that no Republican has done anything to curb the health care insurance industry, was the Senator in the Senate when Senator Kennedy and I fought for weeks and months for the Patients' Bill of Rights? Was the Senator here then? Was he engaged in that debate? Senator Kennedy and I fought for the Patients' Bill of Rights, and the majority on that side of the aisle opposed it. The fact is, there have been efforts on my part to curb the abuses of the health insurance industry by sponsorship of the Patients' Bill of Rights.

Second, during the campaign, yes, I said that we could reduce and eliminate waste, fraud, and abuse in spending, and I said it because of Senator COBURN's Patients' Choice Act which would save $1 trillion in the States in Medicaid savings, $400 billion over the next 10 years in Medicare savings. I wish the Senator from Illinois would examine the Patients' Choice Act, as proposed by the Senator from Oklahoma. Maybe he would learn something. The Coburn bill wants to preserve the best quality health care in America and not eliminate $12 billion in the Medicare Advantage Program, which 330,000 of my citizens who are enrollees like and want to keep, not eliminate $150 billion to providers, including hospitals, hospice, and nursing homes, $23 billion in unspecified decreases to be determined by an independent Medicare advisory board, as well as billions of additional cuts to the Medicare Program.

There is no relation between what I tried to do in my campaign and what is being done in this legislation, I tell my friend from Illinois. I would be glad to hear the Senator's response. I would be glad to extend him that courtesy.

Mr. DURBIN. I thank the Senator from Arizona. I commend him for his work on the Patients' Bill of Rights which I joined him in with Senator Kennedy and would do it again. The point I was making——

Mr. MCCAIN. Your statement was that no Republican had done anything. You just said no Republican had done anything to curb the health insurance industry. The Patients' Bill of Rights certainly would have done it.

Mr. DURBIN. My point was that there are provisions in this bill dealing with the rights of consumers against health insurance companies which I have not heard the Senator or others——

Mr. MCCAIN. That is not what you said.

Mr. DURBIN. I ask you, do you support the health insurance reforms in this bill that give patients rights against health insurance companies; preexisting conditions, for example?

Mr. MCCAIN. My record is very clear of advocating for patients and against the abuses of insurance companies across the board.

Mr. DURBIN. Thank you.

Mr. MCCAIN. I ask unanimous consent to yield to the Senator from Oklahoma to describe the Patients' Choice Act and the way we could truly save money and reduce fraud, abuse, and waste in the system and at the same time preserve quality health care.

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

The Senator from Oklahoma.

Mr. COBURN. There needs to be some clarification. Medicare doesn't cover everything. Eighty-four percent of all

Medicare patients have to buy a supplemental policy now. Do you know what Medicare Advantage is about? Who set the prices on Medicare Advantage? The government set the prices on Medicare Advantage. The very same people you want to run it now created a 14-percent premium. The insurance industry didn't set the prices. The Center for Medicare and Medicaid Services set the prices. The government is responsible for that differential.

Why is Medicare Advantage important? Because the vast majority of the people in my State and every State who have Medicare Advantage can't afford to buy a supplemental policy to make them whole on Medicare, because Medicare won't cover it. So Medicare Advantage for 89,000 Oklahomans is the only way they get equality with the rest of their peer group who can afford to buy a supplemental policy.

Now we are going to take that ability away from poor seniors in Oklahoma, Arizona, Iowa, and Illinois, and we are going to say: You don't get what everybody else has because you are economically disadvantaged. So we are going to give you substandard care, and we are going to take more of your income. Medicare Advantage offers the things you get with a supplemental policy when you can't afford to buy a supplemental policy. The very idea of saying we are going to take that away, when you are taking that away from the cheapest program we have in terms of performance, because what Medicare Advantage does, which their bill and this bill purports to do, is recommends and encourages and incentivizes prevention as the Senator from Iowa wants to do for everybody. It incentivizes it. It doesn't cost to have a prevention exam under Medicare Advantage. There is no out-of-pocket cost for our seniors who are poor who happen to have the benefit of Medicare Advantage. You are going to take that away. You are going to destroy it for 11 million seniors, the ability to get a preclearance, a screening exam, without them having to spend money on it.

Is there a way to get money out of Medicare? Yes, there is $100 billion worth of fraud a year in it. According to Harvard, there is $150 billion worth of fraud a year in Medicare. There is $2 billion worth of fraud.

I want to address something else the Senator——

Mr. MCCAIN. Before the Senator continues, I ask unanimous consent to regain the floor and then yield to the Senator from Oklahoma.

The PRESIDING OFFICER. Is there objection?

Mr. MCCAIN. I ask unanimous consent to engage in a colloquy with the Senator from Oklahoma.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MCCAIN. Mr. President, I have to address the situation since I have been accused by the majority leader of changing my position. The Senate considered the Deficit Reduction Act of 2005 which called for approximately $10 billion in reduction in Medicare costs, approximately $10 billion. Senator HARRY REID, Democrat of Nevada, said:

> Unfortunately, the Republican budget is an immoral document. Let's look at what is in the bill before us. The budget increases burdens on America's seniors by increasing Medicare premiums, and we have not seen what the House is going to give us. It cuts health care, both Medicare and Medicaid, by a total of $27 billion.

The majority leader was outraged in 2005 that there should be reductions in Medicare and Medicaid spending of $27 billion. Now the distinguished majority leader, with the white smoke coming out of his office, says he is for $483 billion in cuts in Medicare. That is a remarkable flip-flop.

By the way, I might add, Senator DODD, who is here on the floor, said, concerning the Deficit Reduction Act of 2005:

> For example, this bill cuts funding for Medicare and Medicaid which provide health care to poor children, working men and women, the disabled, and the elderly.

What a plea. What a plea.

Senator BARBARA BOXER said:

> Mr. President, I strongly oppose the reconciliation bill before the Senate. The bill would cut vital programs for the middle class, elderly, and poor. That is why I cannot believe only 2 months after Katrina we have a bill that would cut Medicare and Medicaid by $27 billion.

The list goes on and on.

Now before us we have cuts of $483 billion, including hospice, hospitals, other vital programs for our seniors. If we are going to go around and talk about flip-flops, let's look at the rhetoric that accompanied my colleagues on the other side in their opposition to $27 billion in savings which, by the way, actually only saved $2 to $3 billion over 5 years.

I ask my friend from Oklahoma, does he believe it is possible to make these cuts, including from the Medicare Advantage Program, and establish a Medicare commission that would not, over time, cut benefits that exist today for Medicare and Medicaid patients?

Mr. COBURN. Mr. President, I would answer my colleague by saying this bill is a government-centered approach, not a patient-centered approach. It is the very reason we are in the trouble we are in today. We have had the government making decisions rather than the patients and the physicians. It will, in fact, lessen the care for seniors.

I gave a speech earlier this morning on the floor that if you are a senior, you should be worried. Because the Medicare Advisory Commission and the cost comparative effectiveness commission will now decide ultimately what you get. We have an amendment on the floor, which in many ways I support but I would like to modify, about reinstituting what should be the standard for mammography for women. How did we get there? We have a commission that looks at cost and not patients. From a cost standpoint, the task force on screening is absolutely right. But from the patient's standpoint, it is absolutely wrong. How do we decide the difference? Do we make the difference based on what something costs or do we make it on what my wife, who will soon be a Medicare patient, receives? The question is, will the cuts that are manifested by this bill impact seniors' care? As somebody who has practiced medicine for 25 years and cared for seniors for longer than that, I will tell you undoubtedly they will have delay, denied care, and 80 percent of them will be fine. But 20 percent of the seniors in this country will be markedly hurt by this bill because a bureaucracy looking at numbers, not patients, never putting their hand on the patient, will make a decision about what is good for them and what is not.

Everything we know about medicine is that is exactly the wrong way to practice it. Every patient is different. Every patient's family history is different. When we talk about taking $120 billion out of the Medicare Advantage Program, what we are talking about is decreasing access to some of the most important screening capabilities that many of these people have and making them unaffordable because they cannot afford a supplemental Medicare policy. They cannot accomplish it.

I want to address one other question. The majority whip said the Republicans have not had a bill. During the markup in the HELP Committee, I went through point by point the Patients' Choice Act. The Patients' Choice Act puts patients and doctors in charge, not the government in charge. The Patients' Choice Act neutralizes the tax effect to make everybody treated the same in this country, as far as the IRS is concerned.

Right now, if you get insurance through your insurance company, you get $2,700 worth of tax benefits. If you do not, you get $100. That is really fair. That is one of the reasons why people who do not get insurance through their employer cannot afford health insurance. It is because we do not give them the same tax benefit. It would give a tax cut to 95 percent of Americans, plus help them buy their care.

The Patients' Choice Act solves the liability problem by incentivizing States to have reforms in terms of the tort problem we have, where we know the cost is at least 6 to 7 percent more that we have spent on health care than we would if we had a realistic tort system.

Finally, we go after insurance companies because we do what is called risk readjustment. If you are dumping patients or cherry-picking—guess what—you have to pay extra; you have to pay to the very insurance companies that are covering those sick people. So we change the incentive to where an insurance company is incentivized to care for somebody rather than to dump them.

I was an advocate, when I was in the House, for the Patients' Bill of Rights.

I was defeated at every turn, trying to make this. To say we did not come with a bill, on a party-line vote in the HELP Committee 13 voted against a commonsense bill that did not increase taxes, did not increase premiums, covered more people than this bill will cover by 4 million, putting everybody in Medicaid on a private insurance policy so no longer are they discriminated against by the doctors who will not take Medicaid, taking the Medicaid stamp off their forehead and giving them the same access to health care we have.

Mr. MCCAIN. So does my colleague find it entertaining that my friends and colleagues on the other side of the aisle, in 2005—as part of the Deficit Reduction Act, we had to bring in the Vice President, who I think was overseas, in order to break the tie because they were worried about what Senator REID called an ''immoral document,'' referring to the Republican budget?

By the way, is the Senator aware that Citizens Against Government Waste has come out in favor of this amendment?

Mr. President, I ask unanimous consent that the letter from Citizens Against Government Waste be printed in the RECORD.

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

COUNCIL FOR CITIZENS
AGAINST GOVERNMENT WASTE,
Washington, DC, December 1, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: You will soon vote on Senator John McCain's (R–Ariz.) motion to commit H.R. 3590 to the Senate Committee on Finance with instructions to remove the drastic cuts made to Medicare. On behalf of the more than one million members and supporters of the Council for Citizens Against Government Waste (CCAGW), I urge you to support this motion.

H.R. 3590, the Patient Protection and Affordable Care Act, would slash Medicare by $500 billion. Depriving seniors of their much-needed benefits is not a responsible way to achieve healthcare reform.

As it currently stands, the legislation calls for significant reductions including $120 billion to the highly successful Medicare Advantage program; $150 billion to providers including hospitals, hospice programs, and nursing homes; and $23 billion in unspecified decreases to be determined by an ''Independent Medicare Advisory Board.''

While CCAGW has been a long-time critic of improper payments and Medicare waste and fraud, the $500 billion in cuts in H.R. 3590 would not solve these inherent problems or help make Medicare solvent. The major reductions proposed to Medicare merely help lawmakers offset the costs of a massive new entitlement program to the detriment of the nation's senior citizens.

I urge you to support Senator McCain's motion to commit. All votes on this motion and other amendments pertaining to Medicare cuts will be among those considered in CCAGW's 2009 Congressional Ratings.

Sincerely,

THOMAS SCHATZ,
President.

Mr. MCCAIN. Also, I say to the Senator, as you know, many of the seniors in my State—I would ask my colleague—have been very puzzled at the AARP's endorsement of a proposal that would cut their Medicare, where it has already been made clear that Medicare Advantage—and there are 330,000 seniors citizens in my State who are under Medicare Advantage—that it has been announced it will be slashed, and that somehow AARP is now supporting it.

All I can say is, is my friend aware there is an organization called 60 Plus that is working very hard on behalf of seniors to make sure they do not lose these benefits?

Mr. COBURN. I am. I would tell the Senator, again—how are we where we are? How are we where we are, when we are going to take a program that is working—granted, I think Medicare Advantage could be decreased through true competitive bidding. But CMS did not do that. We could bring the costs down and still have the same benefits. But this bill cuts the benefits in half, the extra benefits that Medicare patients have by being signed up on Medicare Advantage that everybody has who can afford a supplemental policy.

I want to address one other thing, if the Senator would allow me. The majority whip said: Don't we want to get rid of conflicts of interest? Yes. But his argument was specious because the price is set for an X-ray or a mammogram or a CT or a blood test. They are set by Medicare now. There is no differential in the price other than what Medicare says the differential will be. There is no arbitrariness. The government sets the price for every Medicare test out there by region. So there is no way to game it, as the Senator from Illinois said it was gamed. The best reason to have a lab in a doctor's office is so you do not have to wait and come back for another visit to the doctor who charges Medicare another $60 because you get the answer right then. We want to eliminate that. So what will we do? There is no cost savings in that. There is a cost increase because now, instead of giving an answer to the patient, the patient is going to wait as they send it off to the lab, and have them come back in.

Mr. MCCAIN. Can I ask the Senator another question? How does the Senator envision that we can eliminate fraud and abuse and waste and institute significant savings? One of the ways is to retain the provisions in this amendment, this motion to commit, that uses the savings from fraud, abuse, and waste elimination to make the trust fund stronger, but at the same time preserves the benefits that our senior citizens have earned. How many times have you heard from senior citizens in your State saying: I paid into this trust fund. I paid for my Medicare all my life. Now it is going to be cut. How is that fair? How is that fair to my generation, the greatest generation?

Mr. COBURN. Well, if you take $100 billion a year—and that is not an exaggeration; even HHS, this last week, said their improper payments were $92 billion; the Inspector General and the GAO both say it is higher than that; that is on Medicare alone—if we just captured $70 billion of that.

How do you do that? Do you know how Medicare pays down? They pay and then chase. So you submit an invoice. They do not know if it is accurate. They pay it, and then they go try to get the money back afterwards.

How about precertification of a payment, as everybody else does that has anything to do with the volume that Medicare has? The other way you do it is with undercover patients, where you put people actively defrauding Medicare in jail. Less than $2 billion in this whole bill goes after fraud. That is 2 percent of the fraud per year. We could cover everybody in the country or extend the life of Medicare 20 years by eliminating the fraud that is in Medicare today. What are we going to do? We are not. We are going to create more government programs and more agencies that are going to be designed to be defrauded. So, therefore, the fraud is going to go up, not down. The fraud is going to go up, not down.

We are also going to limit the availability of prevention to seniors. I have read the prevention text in the bill. There are parts of it I absolutely agree with. We know if we manage prevention and we manage chronic diseases, we are going to save a lot of money. But we are not going to save any of it by building jungle gyms and sidewalks. What we have to do is incentivize people, both physicians and patients, to get in the preventive mode. We need accountable care organizations.

There are lots of things we can do. There are lots of things we can agree on. I know the Senator from Iowa and I agree on a lot on the prevention, but we ought to be saving that money, and we ought to eliminate the fraud. If we did nothing in this body except eliminate the fraud in Medicare, think what we would have done, think what we would have done for the kids who follow us.

Mr. President, $447 billion spent on Medicare; $100 billion in fraud. Wheelchairs that have been billed out so many times they have collected $5 million on them, doctors who submit false invoices, suppliers who submit invoices for people who are deceased. And we try to go get that after the fact? There are lots of things we could do. This bill is short on that. You all recognize it is short on it. It is the biggest savings out there. The reason there is not more in it is because CBO will not score it because we have never demonstrated that capability.

One final point. This bill only scores the way CBO scores because it says you intend to do what no Congress has ever done. It says you intend to cut Medicare $460 billion to $480 billion. If you intend to cut Medicare, the American people ought to know where you are going to do it, how it is going to affect them. But if you are just doing it for a

scoring point, the young people in this country ought to know that too. Because where you say you are claiming $460 billion, you are adding to the deficit if, in fact, we do not cut Medicare that much. And is it fair to the Medicare Advantage patients, who are poor—who do not qualify for dual coverage with Medicaid, who cannot afford a supplemental policy—is it fair to take away the benefits they have today that we have given them—and it was not priced by the insurance industry; it was priced by CMS—and say because CMS, the government agency, did not price it, we are going to take away half of your benefits? It is not fair. It is not right. If there is anything immoral, that is immoral.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, the Senator from Iowa is to be recognized next.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Well, Mr. President, sitting here listening to the Senator from Arizona and the Senator from Oklahoma go on, I hardly know where to start. There have been so many accusations and so much misinformation it is hard to know where to begin.

I would begin by, first of all, saying the people who keep saying we are slashing Medicare and we are going to harm seniors are totally wrong. The fact is, the bill we have before us protects Medicare's guaranteed benefits, reduces premiums and copays for seniors, ensures that seniors can keep their own doctors, and ensures Medicare will not go broke in 8 years by stopping the waste, fraud, and abuse.

I might also say, as an aside, every time I hear the Senator from Oklahoma talking about waste and abuse and fraud in Medicare, it sounds like it is all in Medicare. The waste, fraud, and abuse we are talking about are the ripoffs of Medicare by pharmaceutical companies, many of which have been fined big fines and have settled. One of the most recent ones, I think, was almost for a billion-some dollars. It was one of the largest settlements in our history with a pharmaceutical company that was caught ripping off Medicare. And insurance companies have ripped off Medicare, and others. It is not within Medicare; it is those who are coming at Medicare and trying to plunder it.

But that is what we do in this bill: We are stopping that kind of waste and abuse against Medicare; not in Medicare but against Medicare. We provide new preventive and wellness benefits for seniors. We lower prescription drug costs, keep seniors in their own homes, and not nursing homes, with the CLASS Act and the Community Choice Act that is also in this bill.

When they talk about going after Medicare, boy, talk about crocodile tears. Was it not Newt Gingrich, the former Speaker of the House, the leader of the Republican revolution, who said he wanted Medicare to ''wither on the vine''? Was it not Senator Bob Dole, their standard bearer for President in the 1990s, who said he had fought against Medicare and was proud he voted against it? Now, all of sudden, it seems as though Republicans are the guardians of Medicare.

People know the truth. The American people know the truth. They know it is the Democrats who fought for Medicare. Lyndon Johnson, as President, and the Democrats in the House and Senate, if it were not for them, Medicare would have never been passed. It is the Democrats who have fought to keep Medicare alive and well and healthy, and expanding it to people all over this country every step of the way—being opposed by our friends on the other side of the aisle. And now to hear them talk about how much we are going after Medicare, boy, talk about crocodile tears.

The other thing I want to say is that I want to correct something the Senator from Oklahoma said. He talked about the recommendations that recently came out—I will have more to say about this in a minute—on mammograms. He said the U.S. Preventive Services Task Force—all they did was look at costs. That is what the Senator said. They looked at costs but they did not look at the people.

Recommendations that come from the U.S. Preventive Services Task Force cannot take into account cost. Cost cannot be a factor. They can only look at scientific evidence, safety, and efficacy. Cost cannot be taken in as any factor in their deliberations. So I wanted to set the record correct on that.

As I said, there were so many things I heard from the other side it is hard to know where to start. I see my leader here, Senator DODD, who did such a great job in getting our bill to the committee and getting it in the form that it is now and on the floor.

I wish to ask the Senator—I know the Senator was here listening to our friend, the Senator from Arizona, speak. Did it strike you that what he said was kind of missing the mark here a little bit and maybe not quite what we are doing in this bill?

Mr. DODD. I thank my colleague. Just to set the record straight, because it is amazing to me, in a very short amount of time, how people can misconstrue events. First of all, the Senator from Oklahoma was talking about the Medicare Advantage bill, and he said: Do you know who sets the rates? The government sets the rates.

That is true. That is because when that bill was passed, with very few people on this side supporting that bill—almost overwhelmingly on the other side—the requirement under the law, the requirement to pass, mandated under the law that the private plans of Medicare be overpaid, and on average those overpayments averaged 14 percent and in some States over 50 percent. The law that was passed here by the majority—and running the place at the time—insisted upon the mandates being included. So if you wonder why that occurs today, it is because they required it in the law.

Secondly, when you talk about the Deficit Reduction Act of 2005—again, memories fade for some people. In fact, under that bill, children, working families lost the insurance they had. Cuts occurred. Women lost access to mammographies. Cervical cancer screenings were cut. Families lost benefits. There were direct cuts in them. The difference is, today, with what we are talking about, you don't cut these benefits at all—at all. In fact, we are increasing the opportunity for Medicare to be strengthened under this bill. There is a vast difference between what happened in 2005 and what is being supported today. So, again, I just want the record to be clear. You can't make these things up as you go along. That is what happened in 2005. It was an abomination and did great damage to people in this country. People lost their insurance.

Under our bill, 31 million Americans will have coverage. We now know the premiums are going to drop for 93 percent of all Americans. Premiums will actually come down for individuals, small businesses, and large employers. For five out of six people who have their jobs, those premiums come down. Thirty-one million Americans will be covered with health insurance. Compare that, if you will, with 2005 when we actually cut mammography screening, cervical cancer research, and assistance in health care for infants and children and women. That all got damaged in that year. Not in this bill. This is the difference.

I thank my colleague for yielding.

Mr. HARKIN. Mr. President, the only thing I would say to my friend from Connecticut—he said that in 2005 we had made all of these cuts in the Deficit Reduction Act. I just want to say for the record that I didn't vote for it and neither did the Senator from Connecticut.

Mr. DODD. Absolutely not.

Mr. HARKIN. Is this not when the Republicans were in charge and they had a Republican President and a Republican House and Senate? That is when they cut all the mammogram screenings and things such as that?

Mr. DODD. That is true. The record is very clear on this. People had the right to do so; that was their choice at the time. But to try to rewrite history somehow and say those cuts didn't occur—in fact, they did occur in these areas. That is why there were those of us here who objected strongly at the time. My colleague from Arizona is absolutely correct when he said that I said this was going to cut benefits for children and working families and cut screenings and tests for people. It did do that. Those of us who made those warnings on that day were proven to be 100 percent accurate. Compare that, if

you will, with what we are talking about here today, particularly regarding reducing costs, premiums, and providing increased access for millions of Americans. That is the difference.

If you vote for the McCain amendment, we are right back where we were before—right back—which, of course, we all know means premium increases go up by literally 100 percent in the next 7 years. Tell that to a family of four in my State who is paying $12,000 right now and will go to $24,000 in 7 years, as opposed to having those premiums being reduced, depending on if you are an individual, small business, or large employer, by as much as 20 percent, 11 percent, or 3 percent, not to mention, of course, that you will also increase the number of people who will be covered under this.

The present situation runs the risk of bringing our economy to its knees if we don't act. Recommitting this bill—going back, in a sense—would roll the clock back and do great damage to both individuals and to our country economically. That vote in 2005 set us back terribly in this country. This proposal allows us to move forward and provide the coverage a lot of people need.

I thank my colleague.

Mr. HARKIN. I thank my friend for pointing out those facts.

Mr. President, I have a letter dated December 1, 2009, from the National Committee to Preserve Social Security and Medicare. It says:

Dear Senator:

On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit the bill to the Senate Finance Committee.

Much of the rhetoric from opponents of health care reform is intended to frighten our Nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act—

The bill we have before us—

does not cut Medicare benefits; rather, it includes provisions to ensure that seniors receive high quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

I won't read all of it, but it concludes:

The committee urges you to oppose the motion to recommit the bill to the Finance Committee.

Sincerely, Barbara B. Kennelly, President and CEO.

Mr. President, 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:

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
Washington, DC, December 1, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit H.R. 3590, the Patient Protection and Affordable Care Act, to the Senate Finance Committee with instructions to remove important Medicare provisions.

Much of the rhetoric from opponents of health care reform is intended to frighten our nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act, does not cut Medicare benefits; rather it includes provisions to ensure that seniors receive high-quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

The National Committee opposes any cuts to Medicare benefits. Protecting the Medicare program, along with Social Security, has been our key mission since our founding 25 years ago and remains our top priority today. In fact, these programs are critical lifelines to today's retirees, and we believe they will be even more important to future generations. But we also know that the cost of paying for seniors' health care keeps rising, even with Medicare paying a large portion of the bill. That is why we at the National Committee support savings in the Medicare program that will help lower costs. Wringing out fraud, waste and inefficiency in Medicare is critical for both the federal government and for every Medicare beneficiary.

The Senate bill attempts to slow the rate of growth in Medicare spending by two to three percent, or not quite $500 billion, over the next 10 years. However, it is important to remember that the program will continue growing during this time. Medicare will be spending increasing amounts of money—and providers will be receiving increased reimbursements—on a per capita basis every one of those years, for a total of almost $9 trillion over the entire decade. Even with the savings in the Senate bill, we will still be spending more money per beneficiary on Medicare in the coming decades, though not quite as much as we would be spending if the bill fails to pass.

America's seniors have a major stake in the health care reform debate as the skyrocketing costs of health care are especially challenging for those on fixed incomes. Not a single penny of the savings in the Senate bill will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings included in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits; and it will extend the solvency of the Medicare Trust Fund by five years. To us, this is a win-win for seniors and the Medicare program.

The National Committee with urges you to oppose the motion to recommit the bill to the Finance Committee with instructions to strike important Medicare provisions from health care reform legislation.

Cordially,

BARBARA B. KENNELLY,
President & CEO.

AMENDMENT NO. 2791

Mr. HARKIN. Mr. President, I wish to talk about the amendment before us which has been offered by the Senator from Maryland, my colleague, Senator MIKULSKI. I am going to have more to say about the bill and engage with, perhaps, the Senators from Arizona and Oklahoma in the days and weeks ahead on the structure of the bill itself, but I wish to focus on the amendment that is now before us.

First of all, I am proud that this bill, the Patient Protection and Affordable Care Act, makes significant investments in prevention and wellness because I have long believed that such investments are essential for transforming our sick care system—that is what we have now, a sick care system—into a true health care system, one that keeps Americans healthy in the first place. It keeps them out of the hospital. It will keep a check on rising costs in both the public and private health care markets.

It does this in a number of ways. I won't go into all of them, but among the most important is that this bill requires insurance companies to cover highly effective preventive services with no copayments or deductibles—no copayments or deductibles. This is critical because we know that all too often people forgo their yearly checkups or screenings either because their insurance company doesn't cover them or, secondly, because they have high copays or deductibles that make them simply unaffordable. For example, I had a recent conversation with a small business owner in western Iowa, and he and his few employees have a $5,000 deductible. He recently turned 50. His doctor said: Time for you to get your first colonoscopy. Well, he found out that the colonoscopy was $3,000. He has a $5,000 deductible. This is all out-of-pocket. So not being a man of wealth and not having a lot of means, trying to struggle to keep his small business afloat, he is putting it off. He is putting it off. So that is what is happening now. But what we say in our bill is that these have to be covered without copays or deductibles.

There has been a lot of discussion recently on the coverage of preventive services for women in light of the recent recommendations issued by the U.S. Preventive Services Task Force on mammogram screenings. It has been alleged that the Reid bill, like the HELP and Finance bills that preceded it, only requires coverage of those services strongly recommended by the Preventive Services Task Force. This simply is not true. Under the language of this bill, health plans are required at a minimum—at a minimum—to provide coverage without cost for preventive services recommended by the Preventive Services Task Force. Understand that. It only says that health plans are required at a minimum to provide coverage at no cost for certain preventive services recommended by the Preventive Services Task Force. But these are

simply the minimum level, not the maximum. The task force will establish the floor of covered preventive services, not the ceiling. No health plan will be prohibited from providing free coverage of a broader range of preventive services, and in many cases the Secretary of Health and Human Services may well require that. That is because our bill gives the Secretary of Health and Human Services the authority to identify additional preventive services that will be part of the essential health benefits offered by health insurers in the exchange.

The simple fact is, the Preventive Services Task Force cannot set Federal policy and they cannot deny coverage, period, although there has been a lot of misinformation that has gone out about this. They simply give doctors and patients the best medical information, as I said earlier, not based on cost—cost cannot be a factor—but based on science and based upon efficacy and based upon outcomes and nothing else.

Still, I share the concerns of some that the task force has not spent enough time studying preventive services that are unique to women. This is a concern that was raised when the HELP Committee debated the bill in committee. At that time, I worked with the Senator from Maryland, Ms. MIKULSKI, to include language requiring that all health plans cover comprehensive women's preventive care and screenings based upon guidelines supported by what we call HRSA, the Health Resources and Services Administration, again, with no copays, no deductions. That language is in our bill. It was not included in the merged bill. Senator MIKULSKI's amendment which is now before us and which I have cosponsored would add that language—would add that language—like we had in our committee bill, and I strongly urge its adoption.

By voting for this amendment, which I understand we will do in a couple of hours, we can ensure all women will have access to the same baseline set of comprehensive preventive benefits that Members of Congress and those in the Federal Employees Health Benefits Program currently enjoy. Let me repeat that. If you vote for the Mikulski amendment, you will ensure that all women will have access to the same baseline set of preventive services that are enjoyed by Members of Congress, women Members of Congress, and all women Federal employees in the Federal Employees Health Benefits Plan. That is what voting for the Mikulski amendment will do.

Expanding preventive health care is just one of the ways this bill benefits women. Again, our health care system is broken. It is expensive. Today, less than half of women have access to employer-sponsored insurance coverage. Think about that. Less than half of the women in this country have access to employer-based insurance coverage. Again, many of these women work for very small businesses, and they can't afford to provide that kind of insurance coverage.

In most States, it is legal for insurance companies to charge women more than men for the same policy. Women can pay more than double what men pay at the same age for the same coverage. Each year, thousands of women are denied coverage from health insurance companies for preexisting conditions. In many States, a history of hospitalizations from domestic violence is considered a preexisting condition. Think about that. A battered woman lives through domestic violence and now can't get health insurance coverage because of a preexisting condition—being battered. That happens in many States. With these options, it is not surprising that more than 16 million women are uninsured in this country.

Women are often the health care decisionmakers for their families. They face difficult choices daily. One-third of women are forced to make tradeoffs between basic necessities and health care. In 2009, more than one-half of women reported delaying care because of its high cost.

Today, we have the opportunity to fix these problems. This historic legislation now before us increases access to affordable health insurance and ensures that women's coverage meets their health care needs.

We will end premium discrimination against women. We will end discrimination against those with preexisting conditions. We will prohibit the rescission of health insurance coverage because of an illness. We will provide more affordable insurance choices through the health insurance exchange, including a strong public option to increase competition and choice. We will ensure that the policies families buy are good enough. We will require that all insurance policies sold in all markets provide adequate coverage for primary and preventive care, for screenings, maternity services, and many other services that women and their families need to stay healthy.

As has been said many times before, this bill will extend coverage to an additional 31 million Americans who are currently uninsured. As I said, 16 million women in America are uninsured. So that is why Senator MIKULSKI's amendment is so important, vitally important. That is why this bill is so vitally important.

We are going to talk a lot about Medicare. I see the Republicans are focusing on that, although a recent letter I read and had inserted in the RECORD from the National Committee to Preserve Social Security and Medicare says we ought to oppose the McCain amendment. We will hear a lot about that.

What about the women of this country and what is happening to them? The Mikulski amendment addresses that in a very profound way. But then this bill takes it even a step further by making sure that women, many of whom work for small businesses, who are sort of in an uncovered pool, so to speak, out there by themselves, now they can go on the exchange. Now they can get the kind of coverage they need. They will have choices available to them—not just maybe one option and in some States no option. They will have different options available. They will be able to join with other like women around so they will have a bigger pool and better coverage for themselves and their families.

Yes, I can honestly say the health care reform bill before us, the Patient Protection and Affordable Care Act, is a pro-woman bill. It is not talked about a lot, but many of the things in this bill will go to ease the dilemma so many women find themselves in, in this country—providing basic necessities for their children or trying to get health care coverage for themselves. I can tell you so many women whom I have met and talked to have given up on buying health insurance for themselves so they will have enough money to feed and clothe their kids and send them to school. Women should not be forced to make that kind of a choice.

This bill before us will enable women to not have to make that choice. They will be able to get the insurance coverage they need at an affordable price, with the tax credits that are included for low-income women, and they will be able to have the piece of mind of knowing that they and their kids are truly covered with the health insurance they need.

I will keep coming back to these two things, time after time, as we go through the bill: prevention and wellness. Keeping people healthy in the first place is a big part of this bill. If there is one thing that will bend the cost curve, it is putting more focus upfront on prevention and more focus on keeping people healthy in the first place. That will save us money in the future.

The second theme is what this is going to do for the women of America; how is it going to help them and their families to have peace of mind and to have the health insurance coverage they need.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the next four Republican speakers to be recognized be Senators JOHANNS, ROBERTS, HUTCHISON, and CORNYN and for the Democrats to speak in an alternating fashion, with the next Democrats being Senators MURRAY and CANTWELL to speak on the tragic shootings in Washington, and that following Senator ROBERTS, I be recognized.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I yield to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNS. Mr. President, I rise to speak in support of the McCain amendment. I have been down here for a while, and I have listened to the debate on the Medicare cuts.

What strikes me about this debate is that reality sets in. It simply does. There will be a point at which hospitals, hospice programs, and skilled nursing facilities are going to see less money. That is simply the reality of what we are debating.

It is kind of remarkable to me that you could go from a period just a few years ago, where $10 billion over 5 years was described as immoral, and today we are talking about nearly $½ trillion in cuts. That is going to have a real impact on real programs that involve real people in our States.

From our standpoint, we try to look at this in a way that says: OK, if this were to happen, if, in fact, this gets the necessary votes, what impact will it have on real programs in Nebraska?

Let me walk down through that, if I might. For example, more than $40 billion in cuts from home health on the national level would translate back to the State I represent to the tune of $120 million in cuts. By 2016, according to our analysis back home, 68 percent of Nebraska home health agencies will be operating in the red.

In rural areas, as high as 80 percent will have negative margins. If you lose those services in rural areas, they are lost. In fact, they may be lost forever.

Skilled nursing facilities are already struggling to keep their doors open. I visit these facilities when I get back home. Many of us do that. They are already doing everything they can to make ends meet. We are already seeing them go under in community after community. I visit these facilities and they tell me: MIKE, we are just holding on.

Hospice programs in Nebraska have been very well received. Years ago, I might have predicted otherwise. The reality is, hospice has worked well in my State, and I am guessing it is also in other States in the country. A survey reported that 100 percent think access to hospice services is important. This bill cuts $80 billion nationally from hospice programs.

How can we legitimately expect little or no impact, or simply attempt to argue it away, when 38 Nebraska hospice programs are already operating right at the margin? If there is any reduction, they will go out of business.

Hospitals will also see negative impacts. Let me quote, if I might, from a Nebraska Hospital Association letter:

> Our 85 community hospitals have a unique stake in this debate. Not only are we providers of care to more than 10,000 patients per day, we are also one of the largest consumers of health care because we employ 42,000 people. . . . Hospitals are an economic mainstay of the community they serve and we (the NHA) are opposed to all measures that weaken our financial stability and viability.

The Nebraska Hospital Association indicates that disproportionate share hospital cuts will be $128 million. If other hospital cuts are factored in, Nebraska hospitals say they will see a total loss of $910 million.

I visit these little 25-bed hospitals. They have no room for error. There is no margin there. When they lose something such as this, they simply cease to exist. That community, then, is on its way to ceasing to exist.

Finally, it is very clear that Medicare Advantage is on the chopping block. That is 35,000 Nebraskans. No matter how hard you want to argue that, there are 35,000 Medicare Advantage beneficiaries in my State who will experience cuts in the very program that is such an important safety net to them.

CBO, the Congressional Budget Office, estimates reduced benefits from $135 to $42 a month. The so-called extra payments that would be cut are helping Medicare Advantage beneficiaries get very valuable benefits. Many who utilize Medicare Advantage are truly our most vulnerable citizens.

We cannot ignore that important fact. Seniors with a Medicare Advantage plan might receive vision or dental benefits or have their Medicare copayments reduced. In our State—I am guessing this is true of States all across the country—what you see is some of the poorest actually have Medicare Advantage.

If you don't believe me, just yesterday I received a letter from some Hispanic groups which said this:

> With the growing number of Hispanic seniors, one in four of whom have Medicare Advantage, the defunding of the Medicare Advantage program and other Medicare cuts proposed would result in fewer benefits and a significant disruption in the care and coverage senior Hispanic Americans receive.

I ask unanimous consent that this letter be printed in the RECORD.

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

NOVEMBER 16, 2009.

DEAR SENATOR: As organizations that represent Hispanic Americans, we are deeply concerned with the health care reforms currently being discussed. We do not support reforms that will lead to increases in taxes for all Americans but especially for small business owners, cuts in Medicare, and mandates on families and businesses.

Hispanic small businesses are among the fastest-growing sectors in the U.S.—growing at a rate of over three times faster than the national average. We have been hit hard by this slow economy and cannot afford a greater tax burden and mandates on our families and small businesses. The result will be more Hispanics out of work and reduced wages that directly impact low-income and minority communities.

With the growing number of Hispanic seniors, one in four of whom have Medicare Advantage, the de-funding of the Medicare Advantage program and other Medicare cuts proposed would result in fewer benefits and a significant disruption in the care and coverage senior Hispanic Americans receive.

Many of our families came to the United States to escape hardship, pursue business opportunities and enjoy its economic freedoms. We deserve the right to make our own health care choices and not be subjected to costly and inefficient government mandates.

More than 30 percent of Hispanics are currently uninsured, and we want real reform that would help them. These reforms must promote real competition and choice. We want to ensure that Hispanic families have affordable health care, more choices and that their direct relationships with their doctors remain intact and uninhibited by bureaucrats.

Competition-increasing solutions include allowing businesses and individuals to purchase health insurance across state lines, which would make it easier and less costly for small businesses to provide employees with coverage. Allowing groups to join together to purchase insurance—whether they be small business or church or community groups—would also have a significant impact on the affordability of insurance for Hispanics and increase choices.

Government-focused proposals where bureaucrats and not individual business owners will decide what coverage an employer should provide will not help our families or businesses. Also, individuals will be penalized with fines and higher taxes if they do not follow the rules in Washington.

We hope that you will consider these concerns and what is in the best interest of Hispanic Americans, and all Americans, as you vote on health care reform.

Sincerely,

Hialeah Chamber of Commerce & Industries, Hispanic Alliance for Prosperity Institute, Hispanic Leadership Fund, Hispanic Professional Women Association, CAMACOL—Latin Chamber of Commerce of U.S.A.

Patients' First (Pacientes Primero), The Latino Coalition, U.S. Mexico Chamber of Commerce, Virginia Hispanic Chamber of Commerce, Voces Action.

Mr. JOHANNS. How could any Member go back to their State and defend these cuts to services that provide very important health care needs? Americans simply deserve better than that. If we want serious Medicare reform, we should start with true waste and fraud and concentrate on Medicare insolvency—especially when we all agree insolvency arrives in 2017.

What we are doing in these days of debate is truly robbing from Peter to pay Paul—and Peter is soon to be broke. Unfortunately, that is exactly what we are doing. Americans deserve better than the bill we are debating. I can't stand silently and accept a bill that has such dramatic cuts in the services provided to Nebraska seniors.

I will conclude by saying I support the McCain motion to commit to remedy these problems and get us back on track with commonsense reform.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington is recognized.

LAKEWOOD, WA, POLICE SHOOTINGS

Mrs. MURRAY. Mr. President, we are obviously in the middle of a very important debate on health care. I thank the managers of this bill for allowing my colleague from Washington, Senator CANTWELL, and me to interrupt this important debate to talk for a few minutes about a very tragic event that

occurred in Washington over this past weekend.

Just 2 days ago, our State was shocked and saddened and appalled by news of the deadliest attack on law enforcement in Washington State's history. On Sunday morning, just after 8 a.m., a gunman walked into a coffee shop in Pierce County, WA, and opened fire, killing four members of the city of Lakewood Police Department who were going over the details of their upcoming shift.

It was a senseless and brutal killing. It specifically targeted the people who sacrifice each and every day to keep all of us safe—our police officers.

This terrible crime has not only left the families of these victims shattered, but it has shattered our sense of safety and left an entire community and State in disbelief.

It is also part of a shockingly violent month for my State's law enforcement community that has also included a senseless attack on October 31, which killed Seattle police officer Timothy Brenton and left another officer, Britt Sweeney, injured.

These attacks remind all of us of the incredible risks our law enforcement officers take each day and that even when doing the most routine tasks and aspects of their jobs, our law enforcement officers put themselves on the line for our safety.

Today my thoughts and prayers, like those all across Washington State and our Nation, remain with the families of the brave police officers who were killed on Sunday.

Officer Tina Griswold was a 14-year veteran who served in the police departments in Shelton and Lacey before she joined the Lakewood Police Force in 2004. She leaves behind a husband and two children.

Officer Ronald Owens followed his father into law enforcement. He was a 12-year veteran of law enforcement and served on the Washington State Patrol before moving to the Lakewood Police Department. He leaves behind a daughter.

SGT Mark Renninger was a veteran who wore the uniform of the United States before putting on the uniform of the Tukwila Police Department in 1996. He joined the Lakewood Police Department in 2004. He leaves behind a wife and three children.

Officer Greg Richards was an 8-year veteran who served in the Kent Police Department before he joined the Lakewood Police Department. He leaves behind a wife and three children.

Because of this senseless attack, nine children have lost their parents. These were officers—mother and fathers, husbands and wife—who woke up every day, put on their uniforms, and went out to protect our children, our communities, and our safety. On Sunday, they did not come home.

Already in news reports, Internet postings, and candlelight vigils thousands of tributes to these officers' dedication to their families and jobs have been shared. They paint a picture of brave officers who not only kept our communities safe but were also respected and revered members of our communities; a mother and fathers who in the wake of this tragedy will leave young families behind; neighbors and friends who coached softball and helped repair local homes and reached out to help those in need. They are police veterans who helped build the foundation of a new police force. They are public servants who put the safety of all of us behind their own every single day.

Already this year 111 police officers across our country have given their lives while serving to protect us. Each of those tragedies sheds light on just how big a sacrifice our police officers make in the line of duty. But these most recent attacks in my home State also offer an important reminder: that our officers are always in the line of duty, even when they are training other officers or out on routine patrols or simply having coffee.

There is no doubt these senseless attacks have left many law enforcement officers across my State and our country feeling targeted. But there is also no doubt that their willingness to put themselves on the line to protect us will continue unshaken. In fact, over the last 3 days, law enforcement officers from all across my State have risked their own lives in the successful search to find the man accused of this killing and to keep him from hurting more innocent people. That is a testament to the unwavering commitment they make to serve and protect each of us every day. It should remind all of us that these brave men and women deserve all the support we can provide to keep them safe.

No words are adequate to express the shock, the anger, and the disbelief that comes with such a brutal crime. No words will be enough to lessen the loss. Our law enforcement professionals put themselves between us and danger every day.

Right now, in light of such horrible events, we hold them even closer in our thoughts and our prayers.

Mr. President, I yield to my colleague from Washington State, Senator CANTWELL.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I rise today to join my colleague, Senator MURRAY, in expressing my sorrow over the tragedy that struck Washington State and the law enforcement community. I extend the prayers and condolences of the Senate and the entire Nation to the families, loved ones, and colleagues of the four police officers who lost their lives in the line of duty Sunday in Lakewood, WA.

Those four officers, part of Washington's best, are SGT Mark Renninger, Officer Ronald Owens, Officer Tina Griswold, and Officer Greg Richards.

Collectively, they served for 47 years in the line of duty. As Lakewood Police Chief Bret Farrar describes them, they were ''outstanding individuals'' who brought a range of talents to a 5-year-old department.

These heroes, who put their lives at risk for our safety every day, will be deeply missed and never forgotten. The men and women in blue who keep our communities safe make tremendous sacrifices daily, and so do their families.

The senseless tragedy that claimed the lives of these four officers, as my colleague said, the deadliest attack in Washington State history, reminds us of the risk that police officers take every day when they put on their badges.

The risks that police take every day was driven home again today when a Seattle police officer on routine patrol confronted, shot, and killed the person believed responsible for this crime. And at a time when we are all in shock over the loss of these officers, the police remain vigilant. They did not stop doing their job, even when tragedy struck close to home.

I thank all those who participated in the law enforcement's response since this tragedy happened. I thank the Pierce County Sheriff's Office and Sheriff Paul Pastor for the investigation they have led. My heart goes out to the Lakewood Police Department and Chief Bret Farrar.

I also thank the efforts of the Seattle Police Department and the interim Chief John Diaz for his efforts and his agency's work.

In a matter of days, police and public safety officers from all around the country will converge on Puget Sound. They will form a long blue line in a show of respect for those who have fallen—Mark Renninger, Ronald Owens, Tina Griswold, and Greg Richards.

This moving ritual, which happens all too often in our country, speaks eloquently of the solidarity all of us feel with those who risk their lives to keep us safe. This tragedy also struck our State earlier in October when Officer Timothy Brenton was struck down randomly while sitting in his police car.

I hope everyone in this country will take time today and tomorrow and next week, if they see a police officer, to thank them. Thank them for their service. Express your appreciation for the job they do putting themselves at risk for all of us. We did not have enough time to thank Mark, Ronald, Tina, and Greg, but we are thanking them in our thoughts and prayers, and we are sending strength to their families with much love and appreciation for what those officers and their families have done to serve us and their communities.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I am sorry. I think Mr. ROBERTS is to be recognized.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. ROBERTS. Mr. President, I thank the distinguished Senator from Montana and my chairman of the Finance Committee.

Let me say first to the Senators from Washington State that I think all Senators appreciate both Senators bringing to the attention of the Senate the heartfelt feelings in regard to the tragedy that happened in their State. I share their dismay with regard to what has happened. I know the thoughts and prayers of all Senators are with them. I appreciate the remarks they have brought to the body at this time.

I would now like to discuss briefly the motion to commit in regard to Medicare and the tremendous cuts that are proposed in the bill—a bill I define not as the Finance Committee bill, not as the HELP Committee bill, but the bill that was done behind closed doors, which I think was most unfortunate.

This bill slashes—and I think that is the appropriate word—nearly $½ trillion from Medicare. Then it is used to establish a huge new government entitlement program.

Earlier this year during the Finance Committee markup of the health care reform legislation, I offered a nearly identical amendment to the McCain motion to commit we are now considering, which is a motion simply to send the legislation back to the Finance Committee with instructions to strike the cuts to Medicare in this bill. Unfortunately, my amendment during that time failed in committee on a party-line vote.

Let me see if I understand this correctly. Medicare is going broke. It has around $38 trillion in projected future unfunded liabilities. It is a huge, crushing entitlement program that threatens to bankrupt this country. But instead of owning up to this enormous threat and doing something about it for our financial future, instead of considering a Medicare reform bill to address this menace to future generations of Americans, instead of guaranteeing that the government-run plan we currently have remains solvent, instead we are actually cutting some $465 billion from Medicare in order to start a brandnew, huge, crushing entitlement program that makes no sense.

If Medicare needs to be reformed—and I certainly believe it does—then we should be considering a Medicare reform bill right now. We certainly should not be cutting Medicare for the purpose of financing a huge new entitlement program.

My friends on the other side of the aisle have the temerity—that is a pretty strong word, but I think it applies—to assert these huge cuts will actually make Medicare more solvent. Nothing could be further from the truth. I have news for them. Cutting reimbursements to doctors, cutting reimbursements to hospitals and other providers—all providers—and it has been mentioned by my distinguished colleague from Nebraska—home health care providers, hospices is not reform. These cuts will hurt Medicare beneficiaries, our seniors who have worked their entire lives with the promise that this program would support them through their older age.

Medicare already pays doctors and hospitals well below cost—70 percent approximately for hospitals, 80 percent for doctors approximately. The only saving grace is that these providers have the ability to shift their losses on to private payers to keep their doors open or their practices going. But there is a limit to their ability to cost shift. There is only so much the private sector is willing to absorb.

American families already pay—now get this—an extra $90 billion in a hidden tax to make up the Medicare and Medicaid underpayments that we in past years have provided each year. More cuts to reimbursements coupled with the massive increase to Medicaid this bill assumes will push these limits, meaning that fewer doctors will open their doors to new Medicare patients. They are doing that right now. We are rationing right now as to access to doctors who accept Medicare patients, and health care access and quality for our seniors will be compromised.

Take the $105.5 billion cut to hospitals as an example. I know the National Hospital Organization has signed off on these cuts. I don't know why, but they have signed off on these cuts. I also know for a fact they will harm Kansas hospitals. I asked my Kansas Hospital Association—I did, at my request—to run the numbers on how this bill will affect their bottom lines. Their findings are frightening.

According to the Kansas Hospital Association's outside experts, this bill will result in nearly $1.5 billion in losses to Kansas hospitals over the next 10 years. It may be true that some urban hospitals that currently have large percentages of uninsured patients may have some of their cuts offset by the potential reduction this bill will make to the uninsured population. But that is no consolation to a hospital in McPherson, KS, for example, that may be too large to qualify for the higher reimbursements allotted for what we call critical access hospitals, and has, unfortunately, the misfortune of serving a smaller than average uninsured base. Those hospitals will see huge cuts without seeing any of the gains. This bill's $100 billion cut will only hurt these hospitals and their ability to serve Medicare and even non-Medicare patients. Remember the cost sharing.

Medicare's own actuaries at CMS, the Center for Medical Services—sort of an oxymoron—have agreed that the Democrats' cuts to hospitals and other providers could be dangerous and could cause them to end their participation in Medicare. So why are we doing this?

Another huge cut to Medicare in this bill is that $120 billion cut to the Medicare Advantage Program. My distinguished colleague from Nebraska has already talked about that, the effects of Medicare Advantage to Nebraska. Let me talk about Kansas. Close to 11 million, or one-quarter, of Medicare beneficiaries are enrolled in Medicare Advantage; 40,000 of those beneficiaries are in Kansas. I want to read an excerpt from one letter I received from a very satisfied Medicare Advantage customer in Shawnee, KS. Ms. Lila J. Collette is enrolled in Humana Gold Plus, a Medicare Advantage plan. She writes:

> Please use everything in your power to let me and the many, many other people in Kansas who have chosen Humana Gold Plus to keep this wonderful plan.

Ms. Collette is not alone. Satisfaction rates among seniors enrolled in Medicare Advantage plans are very high. I know they are very unpopular to the other side and there are a lot of allegations made, but these people made that decision on their own, so why are we essentially gutting this program that provides quality and choice to our seniors?

I could go on about the cuts to hospice, home health care providers, nursing homes, but I think you get the point. I disagree with the failure to prioritize the solvency of Medicare over the establishment, again, of new government programs. And I certainly will never agree to financing these government expansions by bleeding the Medicare Program dry.

That is why, as I have said, I offered amendments in the Finance Committee markup that would have struck these Medicare cuts. Again, unfortunately, they were defeated on a party-line vote.

As the President is fond of saying, ''Let me be clear.'' This bill is funded on the backs of our seniors and those who provide Medicare to our seniors. This bill slashes Medicare by $½ trillion. This bill threatens access to care for seniors and health care for all Americans. I hope my colleagues will join me in opposing these cuts by voting for the McCain motion to commit.

This is the key vote. Don't kid yourselves, this is the key vote. You are either for protecting Medicare or not.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I wish to once and for all lay to rest this false claim that the pending bill is going to ''hurt seniors'' and is going to hurt providers; it is going to be this long parade of horribles that the other side likes to mention. It is totally, patently untrue, the claims they are making.

No. 1, all the crying allegations on the other side that the underlying legislation cuts Medicare, it cuts Medicare, it cuts Medicare—that is what they say. What they do not say is it does not cut Medicare guaranteed benefits. It doesn't cut benefits. It does reduce the rate of growth that hospitals would otherwise receive. It does reduce the rate of growth that medical device manufacturers might receive. All that is true. So it is true it is cutting the rate of growth of Medicare providers. It is not true that this legislation cuts Medicare benefits. That is not true. The other side would like you to believe that is true by using the words

they choose. By saying ''cutting Medicare,'' they want you to think that is cutting Medicare benefits.

But it is not cutting Medicare benefits. Rather, the underlying bill reduces the rate of growth of government spending on providers, on hospitals, home health, hospice—lots of other providers. That is what is going on here. Don't let anybody fool you. This bill does not cut Medicare benefits. It does not. But it does reduce the rate of growth of providers.

Why are we doing that? First of all, most of these providers, virtually all the providers say—gee, we don't like our rate of growth, the Federal dollars coming to us, cut, but they will go along with it. They are OK with it. Why are they OK with it? Why is the American Hospital Association OK with reducing the rate of growth of hospital payments by $155 billion? Why are they OK with that? They are OK with that because they are going to make it up on volume. This legislation provides coverage for many more Americans. They are going to have health insurance. Americans who do not have health insurance now often have to go to the emergency room of the hospital, the hospital has to provide the care, it is uncompensated care—nobody is paying for those hospital benefits—and that cost is transferred on to private health insurance premium holders. They have to pick it up. On average, that is about $1,000 per family per year.

No. 1, let me repeat, there are no cuts to Medicare benefits. There are reductions in the rate of growth to Medicare providers—which the providers agree with, by and large. I won't say totally, I wouldn't stand here and say they are jumping up and down and they are enthusiastic about it, but I am saying they realize they are not getting hurt. They are going to do OK. They are going to do OK because they are going to make up in volume what they might otherwise lose. That is a very important point for people to understand.

Second, if you listen to the other side, what they would have us do is virtually do nothing. What does doing nothing mean? Doing nothing means the solvency of the Medicare trust fund is just over the horizon. This legislation extends the solvency of the Medicare trust fund another 4 to 5 years. Man, if I am a senior—I am about to be a senior—I would sure like the Medicare trust fund to be solvent. I would like that very much. This legislation extends the solvency of the Medicare trust fund by another 4 to 5 years, to about the year 2017. So without this legislation, the actuaries say the Medicare trust fund is going to become insolvent 5 years earlier, 2012, somewhere there. That is not many years from now; not many years at all. So it is very important we extend the solvency of the Medicare trust fund.

You might ask why is the Medicare trust fund in a little bit of jeopardy? Why is that? The very basic reason is because health care costs are going up at such a rapid rate in America. Our health care costs are going up by 50 or 60 percent more quickly than the next most expensive country. We already are paying per capita 50 percent or 60 percent more than the next most expensive country. So there is a whole host of things we are doing in this legislation to make sure we have some limit over our health care costs.

I realize I misspoke earlier. Currently the Medicare trust fund is due to be insolvent about the year 2017. This legislation extends the solvency of the Medicare trust fund to the year 2022. The principle is the same, just the 5 years is tacked on a little later period of time rather than upfront.

But we are doing a whole host of things in this legislation to reduce the rate of growth of health care costs to people in this country. It is health care costs which are driving up the Medicare trust fund costs so we are doing all we can to extend the solvency of the Medicare trust fund.

People are saying the Medicare trust fund is getting insolvent because baby boomers are retiring, and that will increase the pressure on it. But the Congressional Budget Office did a study 6 or 8 months ago that said about 70 percent of the additional cost of the Medicare trust fund is due to cost increases, it is not due to more baby boomers retiring when they reach the age of 65.

What do some of the groups say about this legislation? Let me say what AARP says. We have a chart here which indicates what the American Association of Retired People says about the underlying bill. If it was cutting Medicare as the other side says, you would think they would not like this bill. You would think they would have problems with it.

AARP has not totally endorsed this bill, but they don't have problems with it because they know we are doing the right thing. What do they say? AARP says:

> Opponents of health care reform won't rest. [They are] using myths and misinformation to distort the truth and wrongly suggesting that Medicare will be harmed. After a lifetime of hard work, don't seniors deserve better?

That is what the AARP says, referring to the distortions, misrepresentations, and untruths, trying to scare seniors, mentioned by opponents of this legislation.

Here is another AARP quote. This is this month:

> The new Senate bill makes improvements to the Medicare program by creating a new annual wellness benefit, providing free preventive benefits, and—most notably for AARP members—reducing the drug costs for seniors who fall into the dreaded Medicare donut hole, a costly gap in prescription drug coverage.

That is a very important point. This bill not only does not cut benefits, it increases benefits for seniors. A big one is referred to right there and that is the so-called doughnut hole, the gap in coverage under the prescription drug program. This legislation in effect says that seniors now who have $500 of their drug benefit, prescription drug benefits paid for when they are in that doughnut hole period, and add to that this bill also says it is all paid for, at least for 1 year, in this doughnut hole. We have to worry about that in subsequent years, but this bill improves the benefits that seniors will get, not take away benefits as the other side would imply.

It is true that private programs, such as Medicare Advantage, are reduced from what they otherwise would be, just as hospitals are reduced in payments from what they otherwise would get. I have a chart here. Let me point out the next chart here, if I could, which shows that the provider groups, hospitals, et cetera, are actually going to do OK under this legislation. What does this chart show? This chart shows that Medicare spending will continue to grow under this legislation. It will grow, and grow by a lot. Here, in 2010, it is $446 billion and you see a steady growth through the 10 years of this bill.

I might say parenthetically, one of the previous speakers said rural health care is going to be hurt, rural hospitals are going to be hurt in this legislation. I do not think that is entirely true. I have a lot of hospitals in my home State of Montana, rural hospitals. They are not upset with this legislation. They say it is OK. They approve it.

In addition, there are no cuts to critical access hospitals. In rural America most of those hospitals are critical access hospitals. So they are going to be OK.

Basically, if we did not pass this legislation, these provider groups—hospitals, nursing homes, home health, hospice, Medicare Advantage, even Part B Medicare improvement—would all increase by about 6.5 percent over the decade. Under this legislation they all increase by about 5 percent over this decade, with a 1.5 percent cut which they basically agree to.

I want to make that point clearly. We are not cutting Medicare. We are not cutting Medicare benefits, but we are reducing the rate of growth of Medicare spending.

Another point I want to make, if I may, is there is nothing new here. Many of the Senators who are advocating killing this bill made the opposite statement not too many years ago. What did they say? They said: You have to reduce the rate of growth in Medicare spending in order to save Medicare benefits. That is what they said a few years ago, exactly what they said. Let me read:

> We propose slower growth in Medicare. Medicare would otherwise be bankrupt.

They are standing on this floor making the opposite statement today, the exact opposite statement today, trying to scare people to kill the bill.

Here is another Senator. I will not embarrass them by giving their names,

but they are Senators who currently serve in this body.

We do heed the warning of the Medicare Board of Trustees and limit growth to more sustainable levels to prevent Medicare from going bankrupt in 2002. That is what is necessary to ensure that seniors do not lose their benefits altogether as a result of bankruptcy in 7 years.

One Senator said that. When? About 14 years ago. Exact same thing that is going on today.

We know, experts know that if we are going to save Medicare benefits, we have to stop overpaying some of the providers, hospitals and so forth. We are overpaying them.

Let me tell you one small example of how we are overpaying them. Did you know that the updates—the fancy term for paying more for hospitals and so forth—did you know they don't take productivity into account when they make these update recommendations? The recommendations are basically made by an organization called MedPAC. MedPAC is a nonpartisan organization composed of doctors and experts that advise Congress on what the payment updates—what the payment increases should be for different groups over the years. We in Congress basically look at them. We try to decide what makes sense, what doesn't, and so forth. But MedPAC has said that this is what we have to do. We have to slow the rate of growth in some of these providers because they are getting paid too much. They are getting paid more than they need to be paid.

I repeat: We are still going to allow 5 percent growth for all the providers over the next 10 years. None of them are really crying wolf, I might say. That is the main point I wanted to make.

I mentioned what AARP is saying. Let me mention the American Medical Association:

[We are] working to put the scare tactics to bed once and for all and inform patients about the benefits of health reform.

That is the American Medical Association. They are referring to the scare tactics of the other side. The AARP and the American Medical Association and others know that no senior will see a single reduction in their guaranteed Medicare benefits under this bill, not a single one.

I might also say that this bill would reduce premiums seniors would have otherwise paid. Much of those savings to seniors comes from eliminating massive overpayments to private insurers; that is, private companies such as Medicare Advantage.

A small point here. When seniors hear the words ''Medicare Advantage,'' they tend to think that is Medicare. It is not. It is a private company. Those are private companies. They were basically enhanced. Under the 2003 Medicare Part D legislation, they were given a lot more money to encourage them to have competition in rural areas. It turns out we gave them way too much additional money. They know it. This legislation is trying to cut back on the excess they were provided back in the year 2003. The cut is about $118 billion over 10 years. I don't have with me how much is remaining. But that 5 percent figure I gave you of growth, that includes Medicare Advantage.

I mentioned already that this legislation would reduce prescription drug costs. That doesn't sound like a benefit cut to me; that sounds like an additional benefit for seniors. We also provide for new prevention and wellness benefits in Medicare. That is an addition. That is not a cut. That is an addition. We are also helping seniors stay in their own homes, not nursing homes. That is a benefit.

It is important to point out here that the opponents of health care reform do not have a plan to protect seniors and strengthen the Medicare Program. They say don't do what they said a few years ago. They say: Commit the bill, do nothing. They say: Go back and start from scratch again. That is basically what they say. If you listen to the music as well as the words, if you read between the lines, basically they are saying: Kill it. Don't do it. That doesn't make sense.

That is what they are saying. I hate to say this because I tend to be a pretty nonpartisan kind of a guy. But these are scare tactics. They are not truths. Sometimes you have to call a spade a spade, and that is exactly what is happening here.

I might say that MedPAC, the outfit that advises us, is nonpartisan. They can't help us decide what to do here. They think Medicare Advantage plans are overpaid by 14 percent. In addition, a typical couple will pay $90 more per year in Part B premiums to pay for Medicare Advantage overpayments even if they are not enrolled in these plans. That is not right.

Medicare home health providers—I gave that list earlier. One small part of that is Medicare home health providers. They have an average margin of 17 percent. That is a little high.

If we are trying to protect Medicare benefits, we have to make sure we are not overpaying the Medicare providers. That is just common sense. It is the right thing to do. So many seniors just need help with their Medicare benefits.

Nursing homes are making profits of 15 percent off of Medicare. In my judgment, that, too, is unacceptable. We have to bring those down within reason.

We have an obligation. This is a government program. We have an obligation to taxpayers to make sure we are not overpaying hospitals and providers. We have to do right by them, make sure they are doing OK, but just not overpay. That is a tough line to draw sometimes. It is a judgment call. But that is what we are doing here.

In addition, the Office of Inspector General has found rampant fraud and waste and abuse in the Medicare Program. There is a lot of fraud and waste in the Medicare Program. The last figure I saw was about $60 billion in fraud in Medicare—providers, frankly, just ripping off taxpayers and seniors. We have added additional provisions in here to outlaw that fraud—additional screening, additional certification, additional ways to make sure that Medicare does a better job, that CMS does a better job in knowing which payments to providers are right and which are not right.

What is the real impact of the Medicare policies here? Let's be clear: The real impact of these policies, even with the Medicare changes in the bill, overall provider payments will still go up. I don't want to beat that horse too much, but I want to make it clear. We are not cutting benefits. We are reducing the rate of growth of spending for health care providers, hospitals, and nursing homes, but we are reducing it in a moderate way. We are not reducing it by too much. As this chart shows, those providers still get at least a 5-percent net increase in payments over the years, and the groups themselves have not really complained about them. Take the pharmaceutical companies, hospitals, nursing homes, home health, hospice—they are not crying crocodile tears because they know they are going to do better under health care reform.

Remember that famous meeting down at the White House not too long ago. The industry came in and talked to the President. Remember what they pledged, all these providers, how much they can cut reimbursements to them? This is including the insurance companies, hospitals, and everybody. They said they would cut $2 trillion over 10 years—$2 trillion. This legislation doesn't come close to cutting $2 trillion. I think the figure is about $400 billion. That is not $2 trillion, that is $400 billion. So we are not hurting them that much. We are not hurting them, frankly. They are doing OK.

I have quotes from hospital associations. This is from Sister Carol Keehan, president of the Catholic Health Association:

Clearly, the Catholic Health Association thinks the possibility that hospitals might pull out of Medicare . . . to be very, very unfounded.

I have heard the claim over here that this legislation is going to cause providers to pull out of Medicare. That is totally untrue. I have so many quotes here from people in the hospital industry who believe this is OK. They are not going to pull out.

Chip Khan, president of the Federation of American Hospitals:

Hospitals will always stand by senior citizens.

I also know some providers are going to do very well under this reform legislation. Wall Street analysts have suggested that many providers, including hospitals, will be ''net winners,'' according to the basic feeling among Wall Street analysts. Under our bill, they estimate hospital profitability

will increase with reform because more and more hospital patients will have private health insurance.

Nobody is going to pull out. They are not going to cut Medicare benefits. It is true that there is a reduction in some of the private plan nonguaranteed benefits companies would give to seniors at the expense of private patients. That is true.

MedPAC has said it should be cut. MedPAC has said it should be cut more. We are giving these plans a break by not cutting them by what MedPAC says they should be cut.

Again, the reductions in this bill—for the providers, not beneficiaries—are far less than the health care industry itself said it could save over the next decade. A reminder: They pledged to save $2 trillion over 10 years. Under this legislation, they are going to be hit for $400 billion.

I mentioned before that the other side has often said this is exactly what we to have do, although today they say: No, no, no. I am not quite sure what the difference is between a few years ago when they said this is what we should do. Perhaps they can explain that.

I might mention, too—and this is very important, although we tend to lose sight of it—under this legislation, we provide delivery system reform.

There is a lot of waste in our health care system—estimates are 15, 20, 30 percent waste in the American system. Why is there so much waste, which means seniors are not given the benefits they should receive, which means private patients generally aren't getting the benefits they should receive because of all the waste? The waste is basically because of the way we pay for health care. We pay on the basis of quantity. We pay on the basis of volume. We do not pay on the basis of quality. To state it differently, a hospital tries to do the right thing, doctors try to do the right thing. They are paid on the basis of how many procedures they provide, basically, not outcomes, not quality. That is the basic root that has caused a lot of the waste in the current American system.

Health care is provided for differently in different parts of the country. The fancy term is ''geographic disparity.'' Health care in one community is practiced one way. Health care in another community is practiced another way. They are very different.

Many of us have read the June 1 New Yorker article written by Dr. Gawande comparing El Paso, TX, with McAllen, TX. I see the two Senators from Texas on the floor. Perhaps they can help us elucidate what is going on in El Paso and what is going on in McAllen. In El Paso, the cost of health care is about half per person what it is McAllen, another border town. Spending per person in El Paso is about half what it is in McAllen. Yet the outcome; that is, how well the patients do, is a little bit better in El Paso than it is in McAllen. Why? According to the author of the article, it is because of how medicine is practiced, what is the ethic, what is the sense in El Paso regarding health care and what is it in McAllen regarding health care. It may be dangerous for me to say so, but according to the author, his conclusion is that in El Paso, it is because the care is more patient centered, it is coordinated care, it is less on making a buck; whereas in McAllen, it is less coordinated care, more specialties in hospitals, a little bit more providers wanting to go make a buck.

The main point is that medicine is practiced so differently all over the country. There are geographic disparities. In Northern High Plains States, it is less spending per person and the outcomes are terrific. In some of the Sunbelt States—and I don't want to step on the toes of any Senators from Sunbelt States—there is more spending and the outcomes are worse. It is just because it is based on volume and quantity, not based on quality.

This legislation starts to put in place ways to move toward reimbursing based on quality, not volume. That, paradoxically, is going to result in lower costs and higher quality—lower costs but higher quality. Virtually all the folks in the health care community—the doctors, hospitals, and administrators I talk to—virtually all agree—I will be very conservative—80 percent agree, 85 percent agree, this is the direction in which we have to go.

This legislation goes in that direction. Failure to pass this legislation, which the other side wants, means we do not do any of that. It means we do not start putting in place ways to more properly reimburse doctors and hospitals and other health care providers.

This bill includes those patient-centered reforms I just mentioned. What are they? They include accountable care organizations, bundling is another concept, reducing unnecessary hospital readmissions, creating innovation centers. This bill starts to do that.

There is something else this bill does but which some on the other side get all exercised over and which I think they get exercised over improperly; that is, ways to start to compare one drug versus another, compare one procedure versus another, one medical device versus another. We have to start doing more of that with a nongovernment agency, with a private-public agency that works together so it gives good, solid information so we have more evidence-based medicine in America.

Right now, a lot of docs want to do the right thing, but what they do depends on the drug rep who comes in their office and starts peddling a certain drug. Docs feel uneasy about that, they do not like it, but they are so busy they see so many patients, it is hard to keep up to date. So we are trying to help them keep up to date with evidence-based medicine, and with a lot more health IT, health information technology, so they can get access to the best evidence through these various organizations.

There are just so many reasons this legislation is so important. I personally believe we have to move a bit toward what is called integrated systems. We hear about Geisinger, the Mayo Clinic, the Cleveland Clinic, Intermountain Healthcare. There is some home health out in Seattle where doctors and hospitals and nursing homes and pharmacists are more integrated, and that, therefore, cuts down on cost, increases quality. It is more patient centered. It is more care coordinated. This legislation helps us move in that direction.

We are just trying to get started with this legislation, get started in doing some of the right things we know we should do. We do not have all the answers. Nobody has all the answers. But if we get this legislation passed, in the next couple, 3 or 4 or 5 years, working with the basic underpinnings of this legislation, we are going to help correct some mistakes. We are going to see some new opportunities. We are going to be working on getting health care costs down, which we have to begin doing to help our people, help our companies.

We are going to work to get more coverage so more people have health insurance. It is an embarrassment today. It is an absolute embarrassment that the United States of America, an industrialized country, does not provide health insurance for its people. It is more than an embarrassment. It is a travesty. It is a tragedy. It is just wrong, it is morally wrong.

So this legislation gets us moving on the right track. It helps Medicare beneficiaries not hurt them, as the other side would like you to believe. It does not unnecessarily harm doctors and hospitals. They kind of go along with this. They kind of know it is the right thing to do. They are still getting big increases in payments, and there are other reforms here which I have not the time to mention tonight. But I strongly urge us to say: Hey, this is the right thing to do. Let's get started. Let's pass this legislation and certainly trounce this committal motion to stop what we are doing. It is not right to stop this. We are getting started. Let's keep going.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I want to talk about health care legislation. That is what we have been talking about now on the Senate floor for the last week. I expect we will be talking about it for quite a long time.

We have just begun considering this bill, and the American people are growing in their opposition. According to a new Gallup Poll released yesterday, American independent voters now oppose this bill by an 18-point margin: 53 percent against it, 37 percent for it. This Gallup Poll states:

Despite the considerable efforts of Congress and the President to pass health insurance reform, the public remains reluctant to endorse that goal.

But this poll is just confirming what we have really known for months; that is, the bill before us—and the one that passed the House before that—is the wrong approach.

We are not against reform of health care; we need reform of health care. People are concerned about the rise of premiums in health care. So we ought to be looking at ways to address that issue. By doing what? By cutting the costs in the system and by allowing people to have more affordable health care options, none of which is in this bill.

Americans do not support $½ trillion in Medicare cuts. They do not support $½ trillion in new taxes. They do not support mandates. They do not support our growing national debt, which has hit its ceiling at $12 trillion. They certainly do not support a government takeover of our health care system.

Let's talk about the Medicare cuts. The Americans who are most impacted are those we are usually trying to protect: our seniors. I hear others on the Senate floor saying there are no cuts to Medicare. I am looking at the language in the bill. I am looking at the description of the bill, and the fact is there is $135 billion in cuts to hospitals, $120 billion in cuts to Medicare Advantage, $15 billion in cuts to nursing homes, $8 billion in cuts to hospice care. That is nearly $½ trillion in Medicare cuts. That is $500 billion.

In Texas, over half a million seniors are enrolled in Medicare Advantage. We know this bill will reduce their choices and the benefits they have today—benefits such as eyeglasses, hearing aids, dental benefits, preventive screenings, flu shots, home care, medical equipment, and more. So more and more seniors are not going to take the Medicare Advantage option which they now take and enjoy. This is not a solid approach.

I have heard others on the Senate floor on the other side of the aisle say it was Republicans who attempted to cut Medicare in previous years. The Republican effort to cut Medicare growth was $10 billion over 5 years. Not one Democrat voted for a $10 billion cut over 5 years. Yet today they are touting a $500 billion cut over 10 years.

Mr. President, $10 billion was out of the question, and $500 billion is now something that can be accepted? There is no reason to cut Medicare by $½ trillion. We should save Medicare. We should make it last longer and be more stable. But $500 billion in cuts is just going to make it worse. It is going to make it insupportable. Health care for our seniors will surely suffer on its face. That is a fact.

It is a fair question to ask: Well, what are Republicans for? Are you for health care reform? Well, of course we are for health care reform. Every one of us pays health insurance premiums, and we know people who are complaining about the rise in premium costs, especially small businesspeople. I sympathize with that. We all do.

So what is our approach? Step-by-step reform. What the American people are looking for is reform that does not cripple the health care industry in our country, that does not bankrupt our country, and that does not include a government takeover of the health care system.

There are commonsense, fiscally responsible reforms that Republicans have been promoting for years and would support today if we could have a bill that had any Republican input whatsoever, which this one does not—allowing small businesses to pull together and purchase insurance.

Sitting on the floor with us today is Senator MIKE ENZI. Senator ENZI was the chairman, previously, of the HELP Committee. He produced a bill. He produced a bill that would have given more people coverage than the bill before us today—allowing small businesses to come together and pool their risk pool, make it larger, and give much more affordable premiums to more small businesses so they could afford to do what every small business wants to do; and that is, offer health care coverage to their employees.

But the Democrats killed Senator ENZI's bill. That would have been the first step to health care reform. We could have passed that years ago and been on the right track increasing the number of people who have affordable options for health care.

No. 2, reducing frivolous lawsuits. Where States have taken the measure to reduce frivolous lawsuits, such as Texas and a few other States, it has been a phenomenal success. It has brought down the cost of medical malpractice premiums for doctors. It has increased the number of doctors who are willing to practice medicine again. It has increased the number of doctors who will go into rural areas that are underserved. It works.

The estimates are that if we had a part of this bill that would reduce frivolous lawsuits, it would save about $50 billion a year. If we could reduce $50 billion out of the cost in the system that is not going for anything productive, we could then put that into either helping shore up Medicare or give the Medicare reimbursements to doctors and health care providers, to hospitals. We could help the system by cutting those costs. That is something Republicans would support in a heartbeat.

How about tax incentives to people who are buying their own health care insurance? If we provided families with a tax credit worth $5,000, it would give them the ability to put that on a health care policy for their families. It would cut the cost and allow them to have an affordable option. Another is a tax deduction above the line or a tax credit, which would be a huge incentive to employers, as well as to individuals, who would be able to have that kind of help in covering the cost of health care. We are willing to support that.

Another is allowing individuals to purchase insurance across State lines; tear down that bureaucracy that keeps people from going across State lines and getting the very best deal for themselves and their families.

Even an exchange could work. That is something that is embedded in the bill, but it is an exchange that has so many mandates that it is going to raise the cost for everyone. Just a simple exchange that has competition and transparency could actually make a difference in cutting the costs of health care.

So I think there are many things we could do to reform health care, if we could have Republican input and a bipartisan bill that would offer more affordable health care coverage to more people in our country. These are ideas that would improve competition in the marketplace, reduce costs, increase access. We do not need a government-run plan to achieve that objective.

I will be offering an amendment that will allow States to opt out, without penalties, of this plan, if it passes, not just the government part of the plan, but all of the harmful measures. We should be providing choices, not forcing people into government plans. States should not be forced to participate in the government plan. They should not be forced to subsidize it. They should not pay for a plan through increased taxes, nor mandates on businesses.

We want businesses to grow. We want businesses to hire people. We want to have jobs created. This bill is a job killer. Has anyone noticed we have one of the worst recessions since the Great Depression in this country, that over 3 million people in this country have lost their jobs this year? Mr. President, 300,000 of them live in my home State of Texas. Yet we are talking about a bill that is going to increase mandates on businesses and surely will reduce the number of people who can be hired. There is a disconnect we need to put back together. We need to talk about options that can work, that can give more people health insurance coverage at a reasonable price and most certainly not be job killers, with mandates and taxes on small businesses that already are having a hard time staying afloat, creating jobs, and providing health care for their employees.

The first amendment we will vote on tonight is the Mikulski amendment that has to do with breast cancer screening and other preventive services for women. Senator MIKULSKI and I have worked together on women's health issues for a long time in this body. Two years ago, we championed the reauthorization of the National Breast and Cervical Cancer Early Detection Program, which provides screening and diagnostic services. So we know how important it is to address women's health care issues.

I was in complete disagreement with this new task force recommendation on

mammograms and the need for mammograms for women under the age of 50. But I am very concerned that with the recent recommendations of the task force and how this health care bill that is before us relies on the task force, that the amendment is not going to do anything to solve that problem. The health care reform bill relies on the task force 14 times, and it even allocates money to pay for advertising the task force recommendations. This amendment does not address the problem. Rather than severing the ties with that task force so it will not become the norm, the amendment now allows yet another government agency, the Health Resources and Services Administration, to interfere with the relationship between a woman and her doctor. So now coverage decisions will be dictated by both the task force and the Health Resources and Services Administration. Instead of letting doctors and their patients make the decision about when a woman needs a mammogram, we have now not one government task force but two that we will have to intervene in that decision. Oh, my gosh, that does not make any kind of common sense. While I agree with Senator MIKULSKI about the great importance of preventive care for women, I disagree with this approach because it still injects a government agency or task force into the decision that is going to determine whether women have access, easy access, full access to the health care of their choice.

The item we will be considering after the Mikulski amendment and the Murkowski amendment is the McCain motion. The McCain motion is going to strike the Medicare cuts from this bill. His motion, which I certainly endorse and support, would send the bill back for a rewrite. It would send it back to the Finance Committee with instructions to give us a new bill that does not include $½ trillion in Medicare cuts, a bill that would not be paid for on the backs of our seniors whom we should be protecting. As I mentioned previously, the bill that is before us would cut nearly $½ trillion—$500 billion—from Medicare. It will not make it stronger; it will fund more government spending, more government takeover in our health care system. Health care reform should not mean slashing Medicare by cutting $½ trillion from seniors' care. This is not reform.

If we can support the McCain motion to go back to the drawing board and look for a way we can have a bipartisan bill that would have Republican as well as Democratic input and agree to step-by-step reforms that would increase access, reduce costs and not take away choices of seniors and certainly not have a government takeover of health care, then I think we could produce something the President would sign and the American people would embrace. Right now, everyone I talk to in Texas is scared to death. They are scared to death of this big government takeover of our health care system because they know that when government gets involved, we are not going to have the quality we have known in the past, that the jobs are not going to be in the private sector, that we are not going to have the choice. When this bill—which relies on this task force 14 times to make the recommendations that would determine what the coverage is of the government plan—was put before us, all of a sudden people started to say women don't need mammograms before the age of 50, when we have always said it was after the age of 40; and after the age of 50, with a doctor's input, and that it would generally be on an annual basis.

The former head of the Red Cross, Bernadine Healy, and many of our health care agencies and task forces said that is going to kill women. That is going to kill women if they don't have early detection. Early detection is all we have for breast cancer right now. We don't have a cure. We only have early detection as a way to fight breast cancer. But all of a sudden, the task force that is relied on by this bill says we don't need mammograms before the age of 50; and after the age of 50, every 2 years, not every year; and after the age of 72, not at all. That is not health care reform. That is not what the President promised, and it is certainly not what Congress ought to assent to.

We can produce health care reform. We can lower the cost. We can give people access. We can give people choices. We don't have to mandate taxes and hurt businesses in this economic climate to do it. We have the capability to do something right. If we pass the McCain motion, we can go back to the drawing boards and do this right. That is the most important thing I hope we will do this week in the Senate for the American people, and they deserve it.

Thank you. I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, I ask unanimous consent, if I may, that I be allowed to speak for 15 minutes and that that time include a colloquy with my colleague, the Senator from Minnesota.

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

Mr. DODD. Thank you, Mr. President. I wish to address a couple issues, if I may; one is this debate about Medicare cuts and savings. Let me put up one chart. I will not spend a long time on this, but I wish to make a point to my colleagues.

About a year ago, the Bush administration sent us a budget. According to the Congressional Budget Office and the Senate Budget Committee, the proposals in the Bush administration's budget in the last year alone called for $481 billion in Medicare savings and cuts. It was not in the context of a health care bill; that was part of a budget proposal. That was $481 billion, according to the CBO just last year. Literally, 12 months ago that was the proposal. In the context of the overall reform of the health care system, in which we are trying to achieve savings to make sure the dollars are going to go further and go for the things that are needed, our proposal calls for $380 billion in savings over the coming 10 years.

I think, again, people need to understand what we are talking about and that is the difference. So a year ago, $481 billion and no health care proposal—just to get to budget proposals. Here we are in the context of over 10 years of trying to put things in this bill to ensure a more solid footing.

The National Committee to Preserve Social Security and Medicare, representing millions of our fellow citizens, wrote a letter to the Senate, every Member, dated December 1, 2009. Senator HARKIN earlier put the entire letter in the RECORD. I am going to read just one sentence from the letter, signed by Barbara Kennelly, the President and CEO of this organization:

> Not a single penny of the savings in the Senate bill
>
> This bill we are debating—
>
> will come out of the pockets of beneficiaries in the traditional Medicare program.

This is an organization that does not bear a political label. It doesn't represent Democrats, Republicans, Independents. It merely spends every hour of every working day assessing what happens to Social Security and Medicare. That is all they do—all they do. Believe me when I tell my colleagues this organization would not make a statement such as this if it were untrue. I know the organization. I know the people involved. They are highly critical of Democrats and have been when they think we have gone too far in various areas. They state, categorically, what this bill does to Medicare.

I ask unanimous consent that the entire letter be printed in the RECORD.

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

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
Washington, DC, December 1, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit H.R. 3590, the Patient Protection and Affordable Care Act, to the Senate Finance Committee with instructions to remove important Medicare provisions.

Much of the rhetoric from opponents of health care reform is intended to frighten our nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act, does not cut Medicare benefits; rather it includes provisions to ensure that seniors receive high-quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

The National Committee opposes any cuts to Medicare benefits. Protecting the Medicare program, along with Social Security,

has been our key mission since our founding 25 years ago and remains our top priority today. In fact, these programs are critical lifelines to today's retirees, and we believe they will be even more important to future generations. But we also know that the cost of paying for seniors' health care keeps rising, even with Medicare paying a large portion of the bill. That is why we at the National Committee support savings in the Medicare program that will help lower costs. Wringing out fraud, waste and inefficiency in Medicare is critical for both the federal government and for every Medicare beneficiary.

The Senate bill attempts to slow the rate of growth in Medicare spending by two to three percent, or not quite $500 billion, over the next 10 years. However, it is important to remember that the program will continue growing during this time. Medicare will be spending increasing amounts of money—and providers will be receiving increased reimbursements—on a per capita basis every one of those years, for a total of almost $9 trillion over the entire decade. Even with the savings in the Senate bill, we will still be spending more money per beneficiary on Medicare in the coming decades, though not quite as much as we would be spending if the bill fails to pass.

America's seniors have a major stake in the health care reform debate as the skyrocketing costs of health care are especially challenging for those on fixed incomes. Not a single penny of the savings in the Senate bill will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings inclued in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits; and it will extend the solvency of the Medicare Trust Fund by five years. To us, this is a win-win for seniors and the Medicare program.

The National Committee urges you to oppose the motion to recommit the bill to the Finance Committee with instructions to strike important Medicare provisions from health care reform legislation.

Cordially,

BARBARA B. KENNELLY,
President & CEO.

Mr. DODD. Thirdly, I wish to commend our colleague from Maryland, Senator MIKULSKI. Again, a lot has been said about her proposal dealing with women's health. Consider these two statistics as we try to get this right: Less than half the women in the United States have the option of obtaining health insurance through a job—less than half. They are forced either to purchase expensive insurance in the individual market or are dependent upon a spouse to provide health care.

Right now, today, whether you are a Democrat, Republican, conservative, liberal, whether you live in Connecticut, Texas or Minnesota, consider this: A healthy 22-year-old woman can be charged insurance rates 150 percent higher than a 22-year-old man in a similar condition. Our bill before us ends that—ends that. If you defeat the Mikulski amendment or recommit this bill, remember tonight or tomorrow, when the vote occurs, that 22-year-old woman and that 22-year-old man have a differential as much as 150 percent in health care premiums. That is what happens at this very hour. The Mikulski amendment changes that as well in our bill, among other things.

Lastly—and then I wish to turn to my colleague from Minnesota—just to remind my colleagues, again, what Senator BAUCUS has done with his committee in the Finance Committee and what we did in the HELP Committee to provide some meaningful advantages and help to people across this country immediately. One, our bill will provide $5 billion in immediate Federal support for a new program to provide affordable coverage to uninsured Americans with preexisting conditions. Coverage under this program will continue until the new exchanges are operating over the next few years.

Secondly, the bill creates immediate access to reinsurance for employer health care plans providing coverage for early retirees. Again, this will help protect coverage, while reducing premiums for employers and their retirees.

The bill also reduces the size of the doughnut hole immediately by raising the ceiling in initial coverage by $500 in 2010, the coming year—immediately. This will guarantee a 50-percent price discount on brand-name drugs and biologics purchased by low- and middle-income beneficiaries in the coverage gap. That is immediate.

Fourth, our bill will offer tax credits immediately to small businesses to make employee coverage more affordable. That is not a year or two or three from now, this is immediate. Tax credits of up to 50 percent of premiums will be available to firms that choose to offer the coverage as a result of the tax break.

Fifth, our bill will require insurers to permit children to stay on family policies until age 26. Right now, that ends at 23. Our bill extends it to 26 immediately, to have this benefit for people across the country who have families and children today who are staying home longer because of the absence of jobs out there for them.

Our bill will provide coverage for prevention and wellness benefits immediately and exempt these benefits from deductibles and other cost-sharing requirements in public and private insurance coverage. Not in a year, not 2 years, not 3 years but immediately when this bill becomes law.

Sixth, the bill would prohibit insurers from imposing lifetime limits on benefits and will restrict annual limits as well.

The bill also would prohibit group health plans from establishing eligibility rules of health care coverage that have the effect of discriminating in favor of higher wage employees.

In this bill, we also establish standards for insurance overhead to ensure that premiums are spent on health benefits. We also require public disclosure of overhead and benefit spending and require premium rebates from insurers that exceed established standards for overhead expenses.

Lastly, it would create new Web sites to provide information on a facilitated form of consumer choice of insurance options. And there are other immediate benefits to this legislation.

I think it is important, as we discuss the bill, that you understand there are substantial and meaningful improvements. We have debated this bill and debated these issues for months and months on end. The time has come to act. That is what we are proposing with this legislation.

With that, I appreciate the indulgence of my colleague from Minnesota. I yield to him for any additional comments he may wish to make.

Mr. FRANKEN. Mr. President, I thank Senator DODD for his leadership on this bill. I want to talk about Senator MIKULSKI's amendment.

First, a little bit about some of the claims that have been made on the floor today about Medicare. Senator DODD pointed out that in the Bush budget—the last Bush budget—there was a bigger cut to Medicare, but not in the context of any kind of health care reform. Senator BAUCUS said it so well about what the cuts are. They are to hospitals, and the hospitals are fine with it. They are not jumping-up-and-down excited about it, but they are fine with it because it comes in the context of health care reform.

We are covering 30 million more people. What does that mean to hospitals? When people come into the emergency room, they have coverage. The hospitals get paid. That is the context in which we are doing this; whereas, when President Bush was proposing those kinds of cuts, they were not in the context of insuring 31 million more people. When the uninsured were going into emergency rooms for the most inefficient care possible—and won't be now—it was costing every American family $1,100 in additional insurance costs. So they are comparing apples and oranges. We are doing so many things, and Senator DODD talked about some of the things this bill does. I want to talk about Senator MIKULSKI's amendment, because women are among the most severely disadvantaged in our current health care system. Right now, health insurance companies can and do discriminate against women solely on the basis of their gender.

Right now, it is legal in many States—again, not in all States, and this is why, when you are talking about getting health insurance from another State, you have to be careful. In Minnesota, we have stronger regulations. In other States, you don't. In many States, it is legal to charge women higher premiums, or deny them coverage at all, if they have had a C-section. It is a preexisting condition. If they have been the victim of domestic violence—in many States in this country an insurance company can deny a woman coverage because she has been the victim of domestic violence, because it is considered a preexisting condition. That is wrong.

I am immensely pleased that under this bill, for the first time, women will have access to comprehensive health

benefits, including maternity care, without having to pay more than their male counterparts. But we can do even more for women's health in this country.

Senator MIKULSKI's amendment improves the bill to make sure women can get the preventive screenings they need to stay healthy. Most important, the amendment will make sure that women have access to these lifesaving screenings at no cost. So it doesn't interfere with a woman and her doctor, as my distinguished colleague from Texas said a few minutes ago. It makes these screenings available at no cost. Why is this important? Because right now, women are delaying or skipping preventive health care because they cannot afford it. That is not just bad for women's health, it is bad for our system because it drives up costs unnecessarily. Even in Minnesota, where we generally do a good job at health care, there are women right now who are not getting the care they need. They are skipping their annual exam because they are uninsured. Women who are uninsured are twice as likely not to get the care they need.

Other women in Minnesota simply cannot afford the coverage they have now. Since 2007, the number of women who have delayed or avoided preventive care because of cost has doubled. The economic crisis has only made things worse. But the economic situation is no excuse. The reality is that women are forgoing preventive services that could save their lives because of the way insurance works now.

Make no mistake what that is about. From 2000 to 2007, the health insurance companies saw their profits increase 428 percent. Women are forgoing preventive measures that could save their lives. Is this the kind of country we want to live in?

There was some good news yesterday. The CBO confirmed what many of us already knew—that with the insurance market reforms and subsidies in our bill, women will be able to purchase better coverage at a lower cost than they would be paying without the bill. That is huge. With Senator MIKULSKI's amendment, we will go even further, guaranteeing that women receive preventive care when they need it, without barriers. These screenings catch potential problems such as cancer as early as possible. This saves lives and, by the way, it saves money.

For example, cervical cancer screenings every 3 to 5 years could prevent four out of every five cases of invasive cancer. Regular screenings could prevent more than half of the cases of infertility. Senator MIKULSKI's amendment will give women the care they need when they need it. This is a huge step forward for justice and equality in our country.

It is also a top priority for me that health reform includes another crucial women's health service, which is access to affordable family planning services. These services enable women and families to make informed decisions about when and how they become parents. Access to contraception is fundamental, a fundamental right of every adult American, and when we fulfill this right, we are able to accomplish a goal we all share—all of us on both sides of the aisle to reduce the number of unintended pregnancies. And so I believe that affordable family planning services must be accessible to all women in our reformed health care system.

We can't wait any longer, and I urge all of my colleagues to stand up with us and support this amendment.

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

Mr. FRANKEN. My apologies to Senator DODD. I guess I, as a freshman, am not necessarily familiar with all the rules. I think that means I must yield the floor, is that right?

The PRESIDING OFFICER. That is correct.

Mr. FRANKEN. I yield to my good friend from Texas.

Mr. BAUCUS. Mr. President, I didn't think there was a time agreement here.

Mr. DODD. Yes, I had asked consent for a time agreement. I suspect we are going to have a lot of time to talk about the bill.

I appreciate the comments of my colleague from Minnesota.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, I want to talk principally about the Medicare cuts in this bill and make sure that people understand the context in which this takes place and what it means in terms of benefits for seniors.

There has been a lot of parsing of language here in a way that I think can perhaps obscure the real impact of these proposals.

First, let me say there is broad agreement that our health care system needs reform. But I thought the purpose of that reform was to lower costs and make it more affordable—not raise premiums, raise taxes, and cut Medicare benefits.

Again, I say to our friends across the aisle, no one wants the status quo. But it is clear that our friends across the aisle are not interested in any proposals from this side of the aisle, as demonstrated by the party-line votes in the HELP Committee and the Finance Committee, and the product coming from the House of Representatives.

This is simply too important to do on a purely partisan basis. Yet that seems to be the intention of the majority. The American people want us to get this right because they understand this impacts 17 percent of our economy, and it affects all 300 million of us. This is important to them. As they have watched these debates and proposals, as they have learned more about them, it is no mystery why public opinion for these proposals has dropped like a rock. Again, it has dropped like a rock.

First of all, on cost, they realize that the proposals as made have masked the true cost of this bill, and there was celebration when the bill came in under $900 billion. Forget the fact it doesn't actually go into effect until 4 years into the 10-year budget window, so it was only 6 years of implementation; and never mind that it didn't include reversing the 23-percent cut in physician payments that go into effect at the first part of next year, unless Congress acts. That was left out intentionally to make this look cheaper than it is.

The Senate Budget Committee has pointed out that this bill, when fully implemented, would cost the American people $2.5 trillion. I have constituents who asked me: Do you know what a trillion dollars is? They say: I don't know. We used to talk about a million dollars being a lot of money, and then a billion dollars. Now we are into the trillions—hence, the bumper sticker ''don't tell Congress what comes after a trillion,'' for fear we will spend it.

This bill, written by the majority leader behind closed doors, increases taxes by nearly $½ trillion on American families and small businesses during the worst recession we have had since the Great Depression. Unemployment is 10.2 percent, and it is perhaps headed higher. This bill proposes to make it harder on businesses to retain employees, or perhaps maybe someday hire employees and bring down that unemployment rate.

This is a job-killing bill. That is why the American people, the more they learn about it, like it less and less. I predict that the longer this debate goes on, the more they learn about it, the less they will find to like about the bill for that and many other reasons.

This bill also, according to the CBO, increases health insurance premiums by $2,100 for American families purchasing insurance on their own. If you are fortunate and you have large group coverage, it is a little better. But for the millions who are not, it increases the cost of their insurance by $2,100 a year.

I want to focus primarily on the cuts in Medicare. When our colleagues celebrate the fact that this comes back budget neutral, let me explain that mystery. That means you have raised taxes so much and cut Medicare benefits so much, you can claim it is budget neutral. I daresay that is not cause for celebration. In order to create a $2.5 trillion new entitlement program—and that is what this is, at a time when the unfunded liabilities of our current entitlement programs go somewhere into the $40 trillion to $60 trillion range—this bill actually cuts $465 billion in payments from Medicare. These cuts include $135 billion to hospitals; $120 billion from 11 million seniors on Medicare Advantage, including a half million—or to be more precise, 523,000 Texans who depend on Medicare Advantage will see a cut in benefits because of this proposal if it passes.

Mr. President, $15 billion will be cut from nursing homes, $40 billion will be

cut from home health agencies and $8 billion from hospice care.

You can try to parse those words and say we really are not cutting Medicare, but we are cutting Medicare Advantage. Indeed, the Obama administration's own Actuary at the Center for Medicare and Medicaid Services said Medicare cuts of this size would hurt seniors' access to care for several reasons.

First, let me start with Medicare Advantage. Medicare Advantage provides benefits over and above Medicare fee for service. But I think we need to understand that with regard to Medicare fee for service in my State, the last time I checked, 42 percent of physicians will not see a new Medicare patient because the payment rate is too low for the doctors to be able to break even or maybe perhaps earn a small profit. Again, 42 percent of Medicare patients are denied access to a doctor in my State because Medicare payments are so low.

What we did a few years ago was pass the Medicare Advantage Program, which was created to give seniors choice. In other words, there has been so much celebration of the public option or the government-run plan. We have a government-run plan now—Medicare fee for service, which has, depending on where you read, somewhere between an 8- to 12-percent faulty payment rate. In other words, it pays somewhere around 7.8 to 12.4 percent of bills it does not owe to people who do not deserve it, diverting that money away from payment for beneficiaries.

We decided a few years ago to give Medicare beneficiaries a choice—something I thought we all were for—a choice that provided better care coordination and better benefits. Today, 11 million seniors, including the 532,000 I mentioned in Texas, have chosen Medicare Advantage. But this bill, if passed in its current form, will take away health care benefits from those 11 million seniors on Medicare Advantage by cutting $118 billion from the program.

During the Finance Committee markup, the Congressional Budget Office acknowledged that Medicare Advantage cuts would mean fewer services, such as dental or vision.

Senator MIKE CRAPO asked this question:

> So approximately half of the additional benefit would be lost to those current Medicare Advantage policyholders?

Congressional Budget Office Director Doug Elmendorf said:

> For those who would be enrolled otherwise under current law, yes.

So approximately half the additional benefit would be lost to those current Medicare Advantage policyholders.

What happened to the President's promise that if you like what you have now, you can keep it? This is another example of a promise that breaks under this bill, in addition to the $2,100-per-family premium increase for those who buy their insurance on the individual market.

Despite the fact that this bill cuts $465 billion from the Medicare Program, it also fails to deal with draconian cuts that will go into effect in January, unless Congress acts, which will further ensure that seniors will be less likely to see a doctor in 2012. We all know this is sometimes called the doc fix, but this is basically a misguided decision Congress made back in the late nineties to cut provider benefits, thinking that they could do so and it would not have any impact on access to care. But what it has done is while on one hand Congress can stand here and say: Yes, we kept our promise to seniors by providing Medicare coverage, seniors are finding it harder and harder to find a physician who will actually see them because of those low reimbursement rates. This bill does nothing to cut the 23-percent cut in those benefits in 2012 which will have an extremely negative impact on seniors' ability to see a doctor.

We know the majority leader tried, on a standalone bill, to address this issue earlier. But it was not paid for. On a bipartisan basis, Senators in this body rejected sending a bill for $200 billion more to our children. We said we need to be responsible and pay for the bill.

Then the President said health care reform would be paid for by dealing with waste, fraud, and abuse in Medicare. But that is not what this bill does. The Congressional Budget Office said the Reid bill only saves $5.9 billion from reducing waste, fraud, and abuse—$5.9 billion in a bill which over a full 10 years of implementation will cost the American taxpayers $2.5 trillion.

Instead of cutting Medicare, we should be addressing this problem. We know it is a serious problem. The Obama administration found that there was at least $47 billion in Medicare fraud, and that is a conservative estimate. According to Harvard professor Malcolm Sparrow, Medicare fraud may consume as much as 15 to 20 percent of the $454 billion Medicare budget. That means the amount lost to fraud each year in Medicare alone is $70 billion to $90 billion. As I mentioned, improper payment rates, depending on where you look, range anywhere from 7.8 percent of all Medicare payments paid improperly to as much as 12.4 percent, depending on where you look.

Defrauding Medicare has become so lucrative that even the Mafia and other organized criminals are getting into the act. According to the Associated Press last month, members of a Russian-Armenian crime ring in Los Angeles were indicted for bilking Medicare of more than $20 million, and a week after the FBI issued search warrants for a Medicare fraud investigation in Miami, the body of a potential witness was found in the backseat of a car, riddled with bullets.

Earlier this year, I introduced a bill which I hope our colleagues on the other side of the aisle will look at as a way to change the paradigm in terms of the way we address this problem of Medicare fraud. Rather than the pay-and-pursue model, we would have a model which would actually detect potential fraud on the front end by certifying payees and otherwise making sure that money is spent properly. We need to implement commonsense solutions such as this to fix fraud in Medicare before we simply cut in half or cut $½ trillion out of benefits in provider benefits to create a new entitlement.

We all understand Medicare is in miserable shape financially—miserable shape. If nothing is done, Medicare will go broke in 2017, according to the Medicare trustees. The Medicare part of entitlement problems has unfunded liabilities—promises Washington made but cannot keep and does not know how to pay for, nearly $38 trillion. Mr. President, $38 trillion is more than three times the current national debt of $12 trillion, and $38 trillion translated into the burden on every American family means that each American family owes $322,000—more than most American families' homes are worth.

The bottom line is, it is simply irresponsible, without fixing Medicare, without fixing the fraud and the waste—which I know the Presiding Officer is as concerned about as I am—and without dealing with the fact that Medicare promises coverage but denies access because of low payments, to pillage nearly $½ trillion from the bankrupt Medicare program to create a new budget-busting entitlement program.

There had been some talk on the floor about earlier attempts to reduce the rate of growth of Medicare. Interestingly, back in 2005, when there were some proposals to do just that—but, frankly, the numbers paled in comparison: about $10 billion in cuts compared to $500 billion in cuts—the majority leader called those cuts immoral. I have a long list of comments made by our friends across the aisle which stand in stark contrast to the comments they are making today.

Frankly, we need to do something about the insolvency of Medicare. Even if we did not do anything else, that would be a great benefit to the seniors to whom we promised health coverage but who are currently denied coverage because of the problems I talked about.

I know the distinguished chairman of the Finance Committee talked about the sterling endorsements that come from a variety of Washington-based advocacy groups. One of them is the AARP, the American Association of Retired Persons.

Mr. President, I ask unanimous consent to have printed in the RECORD an article about AARP dated October 27 at the conclusion of my comments.

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

(See exhibit 1.)

Mr. CORNYN. Mr. President, what this article demonstrates is that one reason AARP might be opposed to maintaining Medicare Advantage and

be for the cuts in benefits to current Medicare Advantage beneficiaries is because that group and its subsidiaries collected more than $650 million in royalties and other fees last year from the sale of insurance policies, some of which are designed to fill that gap between Medicare fee for service and what it actually costs to get to see a doctor. It is a conflict of interest for this association. Frankly, I don't think its endorsement is worth the paper it is written on, just like other associations that, contrary to the best interests of their members, have made a deal that is bad for the American consumer. The American consumers know it. They know a bad deal when they see it—a deal that includes increased premiums, higher taxes, and cuts in Medicare. Frankly, I think those people with such glaring conflicts of interest should not be in the position of trying to endorse something that is basically going to enrich them to the detriment of the American people.

I plan to offer amendments about this bill's provisions as currently proposed to cut $½ trillion from the Medicare Program. My first amendment would make Medicare play by the same financial solvency rules as private insurers.

We hear our friends on the other side of the aisle talk about insurance companies. I have no doubt that their desire is, frankly, to do away with private sector involvement in the health coverage field, which leaves, of course, only the Federal Government—ultimately a single-payer system making decisions out of Washington, DC, that affect the health care delivery of 300 million people—a bad idea.

My first amendment would make Medicare play by the same financial solvency rules as private insurers. Because private insurers are owned by their shareholders and have fiduciary responsibilities, they could not do business the way Medicare does. They could not tolerate high fraud, waste, and abuse rates. They could not function based on the same risk-based capitalization that private insurance companies do. My amendment would ensure that before we pillage $½ trillion from the Medicare Program to pay for yet another unsustainable entitlement program, the Medicare Program should be able to meet the same solvency and risk-based capitalization requirements private insurance plans meet.

My second amendment will be to strike the unelected, unaccountable board of bureaucrats known as the Medicare advisory board.

We have heard this Medicare advisory board extolled, but this is the same kind of unelected, unaccountable board that we saw just a couple of weeks ago issued a new order or recommendation on mammograms based on cost-benefit, which would have condemned some women between the age of 40 and 49, denied them access to a mammogram and, frankly, condemned them to an early, premature death because of breast cancer. When you put all the power to determine the coverage and also payment in an unelected, unaccountable board, such as the Medicare advisory board, then, frankly, you are going to get more of that rationing and that same sort of cost-benefit analysis which is going to consign too many Americans to a premature death because, frankly, the Federal Government doesn't care and is not going to see them get access to care.

After the Reid bill pillages $465 billion from the Medicare Program to create a new entitlement, it sets up this new Medicare advisory board, an unaccountable board of bureaucrats, to find more ways to cut billions of dollars from Medicare. Unsurprisingly, patients, providers, and even Congress don't always agree with experts, including the ones we have in place today. According to the Wall Street Journal, the Medicare Payment Advisory Commission, created by Congress in 1997, has recommended more than $200 billion in cuts in the last year alone, which lawmakers—that means Congress—has ignored.

Artificial and arbitrary budget targets leave little room for innovation as well. What if we were to find a cure for Alzheimer's in 2020 but because it would be too expensive, the Medicare advisory board would say the Federal Government is not going to pay for it?

Some have said this independent board would be a way to insulate Medicare payment decisions from politics. But the very creation of the Board was the result of a political deal with the White House that insulated hospitals from future cuts.

I wish to close by saying I hope my colleagues will reconsider and vote for the McCain amendment, which will reverse the pillaging of $½ trillion from the Medicare Program to create a new entitlement program. We should fix Medicare's unfunded liabilities of nearly $38 trillion and not steal from Medicare to create another unsustainable entitlement program that will, of course, have to be paid for by our children and grandchildren on top of all the other debt we are piling on them. At a time of insolvent entitlement programs, record budget deficits, and unsustainable national debt, this country simply cannot afford to spend $2.5 trillion on an ill-conceived Washington health care takeover.

I yield the floor.

EXHIBIT 1

[From the Washington Post, Oct. 27, 2009]

AARP: REFORM ADVOCATE AND INSURANCE SALESMAN

(By Dan Eggen)

The nation's preeminent seniors group, AARP, has put the weight of its 40 million members behind healthcare reform, saying many of the proposals will lower costs and increase the quality of care for older Americans.

But not advertised in this lobbying campaign have been the group's substantial earnings from insurance royalties and the potential benefits that could come its way from many of the reform proposals.

The group and its subsidiaries collected more than $650 million in royalties and other fees last year from the sale of insurance policies, credit cards and other products that carry the AARP name, accounting for the majority of its $1.14 billion in revenue, according to federal tax records. It does not directly sell insurance policies but lends its name to plans in exchange for a tax-exempt cut of the premiums.

The organization, formerly known as the American Association of Retired Persons, also heavily markets the policies on its Web site, in mailings to its members and through ubiquitous advertising targeted at seniors.

The group's dual role as an insurance reformer and a broker has come under increasing scrutiny in recent weeks from congressional Republicans, who accuse it of having a conflict of interest in taking sides in the fierce debate over health insurance. Three House Republicans sent a letter to AARP on Monday complaining that the group was putting its ''political self-interests'' ahead of seniors.

GOP lawmakers point to AARP's thriving business in marketing branded Medigap policies, which provide supplemental coverage for standard Medicare plans available to the elderly. Democratic proposals to slash reimbursements for another program, called Medicare Advantage, are widely expected to drive up demand for private Medigap policies like the ones offered by AARP, according to health-care experts, legislative aides and documents.

Republicans also question the high salaries and other perks given to some top AARP executives, who would not be subject to limits on insurance executives' pay included in the Senate Finance Committee's health reform package. Former AARP chief executive William Novelli received more than $1 million in compensation last year.

''We are witnessing a disturbing trend of handouts to special interests like AARP,'' said House Republican spokesman Matt Lloyd, referring to Democratic negotiations over health reform. ''In return, AARP is lobbying for a government-run health-care bill that will pad their own executives' pockets at the expense of its own members and other vulnerable seniors.''

AARP officials strongly dispute such allegations, arguing that the group's heavy reliance on brand royalties allows it to offer members a wide range of benefits—from lobbying for seniors in Washington to discount travel packages and financial advice. The organization notes that even though it offers a Medicare Advantage plan, it has long advocated curbing waste in that federal program.

''We're a consumer advocacy organization; we're not an insurance firm,'' said David Certner, AARP's director of legislative policy. ''That drives everything we do. It's got to be good for our members, or we don't endorse it.''

Added AARP spokesman Jim Dau: ''We spend far more time at odds with private insurers than not.''

AARP's ties to the insurance business date to its founding by former educator Ethel Percy Andrus, who started a group to help retired schoolteachers find health insurance in the years before Medicare; the effort led to the creation of AARP in 1958.

Now, the group relies more than ever on payments from auto, health and life insurers, according to financial statements. From 2007 to 2008, AARP royalties from insurance plans, credit cards and other branded products shot up 31 percent—from less than $500 million to $652 million—making such fees the primary source of revenue for the group last year, the records show. AARP's annual

financial report shows that 63 percent of that, or about $400 million, came from the nation's largest health insurance carrier, UnitedHealth Group, which underwrites four major AARP Medigap policies. Other carriers with AARP-branded plans include Aetna Life Insurance, Genworth Life Insurance and Delta Dental.

AARP is also a major powerhouse in Washington, spending more than $37 million on lobbying since January 2008. The organization's close ties with insurers have long attracted criticism from politicians of both parties.

During the health-care debate of the early 1990s, then-Sen. Alan Simpson (R–Wyo.) held hearings lambasting the group's business operations. Some Democrats criticized the group for supporting the Bush administration's expensive Medicare prescription-drug legislation in 2003.

Earlier this year, AARP and UnitedHealth said they were halting the sale of ''limited benefit'' health insurance policies after complaints from Sen. Charles E. Grassley (R–Iowa) that the plans were marketed in a misleading way.

Dean A. Zerbe, a former Grassley senior counsel who is now national managing director at the corporate tax firm Alliant Group, argues that AARP's involvement in the sale of insurance plans ''really hurts their credibility.''

''Either you're a voice for the elderly or you're an insurance company; choose one,'' Zerbe said. ''They put themselves forward in the public arena as nonbiased observers, but they're very swayed by business interests.''

Republicans renewed their attacks on AARP this year after the group emerged as a vigorous defender of many of the reforms under consideration by the Democrat-controlled Congress. Nancy LeaMond, an AARP executive vice president, appeared at a press conference Friday alongside House Speaker Nancy Pelosi (D–Calif.) to announce a new proposal for plugging gaps in coverage of Medicare prescription benefits.

Rep. Dave Reichert (R–Wash.), who has asked AARP to provide him with more details about its insurance-related businesses, said he believes the group is ''misleading'' its members about the alleged benefits of Democratic reforms. ''Right now there's a feeling among seniors that AARP may not be entirely forthcoming,'' he said.

AARP launched a ''fact check'' section on its Web site this year to counter GOP criticisms of reform, including the discredited ''death panels'' claim, and argues that wringing savings out of Medicare and closing gaps in prescription coverage will help older Americans.

Several top AARP officials also said they have no idea whether the group might gain insurance business as a result of the proposed reforms. ''We wouldn't know it, and we wouldn't really care,'' Certner said. ''The advocacy is what drives what we do here, and not the other way around.''

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I understand we have several Senators who wish to speak. First, the Senator from Michigan, Ms. STABENOW, then Senator HATCH; Senator CARDIN would be third. I don't want to tread on any toes. I say to Senator CARDIN, there is a little bit of time constraint.

We are alternating. We are respecting the alternating back and forth.

The Senator from Michigan is next, Ms. STABENOW.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I, first, thank our distinguished leader on the Finance Committee. It is my pleasure to serve on the Senate Finance Committee. We have been working on this issue for well over a year—2 years now. I very much thank the Senator from Montana and appreciate his leadership in getting us to this point because I don't think we would have been here without his leadership. I very much appreciate that, as well as our leader, Senator REID, who has worked tirelessly, and, of course, the Senator from Connecticut, Mr. DODD, and Senator HARKIN from Iowa as well. We certainly appreciate their leadership.

The bottom line of the legislation in front of us is very simple. On behalf of the American people, we have put forward a health care reform bill that will save lives, it will save money, and it will save Medicare. It does that in multiple ways.

I wish to spend just a few moments this evening talking about Medicare because there is a very significant amendment in front of us that would undercut what we are trying to do to save Medicare. As we go through this next debate, as I have done many times, I am going to continue to talk about the ways in which we are saving lives and saving money.

The reality is, Medicare is a sacred trust with America's seniors, with people with disabilities. Our health care reform efforts, both in the House and the Senate, will help ensure that trust is never broken. That is what this is all about. In fact, I don't think I could look my 83-year-old mother in the eye, knowing how much she has benefited from Medicare, and be doing anything that would weaken Medicare—now or on into the future.

We are going to extend Medicare solvency while providing better, more affordable care for America's seniors and people with disabilities. In fact, we are going to add 5 years to the Medicare trust fund solvency, which is extremely important. In the long run, I expect, as we go forward, as we bring down costs, as we save money, we will, in fact, be adding years to the trust fund by what we are doing.

We are going to crack down on waste, fraud, and abuse in the Medicare Program and wasteful overpayments to insurance companies through a Medicare Advantage effort that essentially was set up to privatize Medicare—turn it over to primarily for-profit insurance companies.

Reform is going to make sure we have more affordable services for seniors. We are going to begin to close that doughnut hole, a gap in prescription drug coverage, right now. It was passed a number of years ago—and I might indicate not paid for—and our effort is entirely paid for. It does not add a dime to the national debt. In fact, it brings down the deficit. But we are closing a gap in coverage on prescription drugs by 50 percent. We are going to phase that in. We are going to keep going until we get that completely closed.

We are going to make sure preventive services do not have a cost connected with them—no deductible, no copay. We want people to be getting the cancer screenings, the mammograms, the wonderful colonoscopies, the other preventive services people need, as well as being able to have a yearly physical with their physician, without deductibles and copays. We are going to aggressively attack fraud and abuse that raises Medicare costs for seniors and for taxpayers.

Reform is also about improving quality of care. It will move Medicare toward a system of rewarding high-quality care, investing in innovations, more efforts in primary care, family doctors, better coordination of care, cutting down on duplication of tests and bureaucracy and all those things we so frequently complain about in the Senate—as we should.

It is going to make long-term care services more affordable. There is such a growing demand and need for long-term services.

It is going to eliminate the imminent physician payment cut that threatens to stop seniors from having full choice of seeing their own doctor. As my colleagues know, I am deeply committed to permanently fixing a flawed physician payment system, but in this bill we make sure the 21-percent cut that is scheduled to take place next year does not take effect, and we will continue. We are committed to working until we completely solve this problem.

It is not a surprise our Republican colleagues are opposing a plan that actually protects Medicare, it actually protects Medicare benefits for seniors, people with disabilities, and keeps Medicare finances in the black for 5 additional years. Just months, 7 months ago, nearly 80 percent of the Republican House Members voted to end Medicare as we know it by turning it into a voucher program that provides a fixed sum of money to pay to private insurance companies, which, by the way, has led—we are now trying to fix overpayments to private for-profit insurance companies at the expense of Medicare and services for seniors.

A top AARP policy official called this scheme that was supported by 80 percent of the House Republicans, just 7 months ago—called this scheme ''a very dangerous idea,'' saying it would raise costs for all beneficiaries and lower the quality of care for less-affluent seniors, lower income seniors.

Now faced with a plan that actually strengthens Medicare, actually saves Medicare for the future and makes sure money goes to Medicare beneficiaries rather than to insurance companies in high payments, some colleagues are pulling out all the stops to defend the health care status quo that sends hundreds of billions of dollars in overpayments to private insurance companies. That is, unfortunately, the result of the McCain amendment, which I strongly oppose.

Many Republicans are resorting to traditional scare tactics and falsehoods, myths. We have heard this over and over. You can go to the AARP Web site and see the fact that, time after time, they have put up falsehoods to try to scare seniors, which I think is outrageous. For proof of how politically motivated these attacks are on the President's proposal and our proposals to eliminate waste and insurance company overpayments in Medicare Advantage, you have to look no further than the fact that a group of Republican Senators actually introduced a similar proposal as recently as this past May.

These kinds of distortions, the fear tactics that have been used, would be offensive under any circumstance, but they are especially disingenuous coming from a group of people who have a long history—a party that has a long history of opposing Medicare and that very recently tried to kill the program as we know it. Their most recent assault was just the latest in a war that Republicans have been waging on the program since the beginning when a majority of them voted no on even establishing Medicare. The overwhelming majority of Republican colleagues voted no.

Last time we had a Democratic President, leading Republicans across the country launched a vicious attack on Medicare. They bragged about opposing the creation of the program in the first place. They called for huge cuts to Medicare and even the ''elimination'' of entitlement programs such as Medicare, as we know them. One even blamed seniors' greed for Medicare's budget problems.

As we now debate this issue, I find it so interesting that colleagues on the other side of the aisle are indicating that, after years of history of trying to cut, eliminate, change Medicare, Republicans having voted against even establishing Medicare, that somehow they are now the protectors of Medicare. As AARP has said, there is nothing in this proposal that is going to cut benefits or increase out-of-pocket costs for seniors. They would not be supporting the efforts we have been involved with if, in fact, it did. I think we all know that.

President Obama and the Democratic majority in this Congress are committed to protecting and strengthening Medicare, a program we created—I should say my predecessors. I was not here. I was not fortunate enough to be here, but it was Democrats who created that program. I am very proud of it because it is one of the great American success stories, Medicare and Social Security. It is a sacred trust with our seniors, and our health insurers reform plan will ensure that trust is never broken.

Health care reform is about saving lives, saving money, and saving Medicare.

I yield the floor.

The PRESIDING OFFICER (Mr. TESTER). The Senator form Utah is recognized.

Mr. HATCH. Mr. President, I am honored to be able to speak on the floor on this very important set of issues. I rise in support of Senator MCCAIN's motion to recommit in order to eliminate the Medicare cuts contained in the legislation.

I do have to say, having listened to my friend from Michigan—and she is a good person and good friend of mine—I have to say I do not see how in the world taking $500 billion from Medicare is good for the Medicare Program. When you start talking about: We are going to find it in fraud, waste, and abuse, that is the biggest dodge that has been used for years and years. Frankly, it is not good for the Medicare Program, it is not good for Medicare beneficiaries, and it is simply not true. How can cuts of that magnitude, $500 billion, $½ trillion, be good for the program?

I support Senator MCCAIN's motion to recommit the Reid health care bill in order to eliminate the Medicare cuts contained in this legislation. Throughout the health care debate, we have heard the President pledge not to ''mess'' with Medicare. Unfortunately, that is not the case with the bill before the Senate, H.R. 3590, the Patient Protection and Affordable Care act. Interesting name. To be clear, the Reid bill cuts Medicare by $465 billion to fund a new government program. Unfortunately, our seniors and the disabled are the ones who suffer the consequences as a result of these reductions. Medicare is very important to the 43 million seniors and disabled Americans covered by the program. Throughout my Senate service, I have fought to preserve and protect Medicare for both beneficiaries and providers. Medicare is already in trouble today. The program faces tremendous challenges in the very near future. The Medicare trust fund will be insolvent by 2017, and the program has more than $37 trillion, almost $38 trillion in unfunded liabilities. So we are going to take $500 billion more out of Medicare? That doesn't make sense. Every senior in this country ought to be up in arms about it.

The Reid bill is going to make a bad situation much worse. Why is that the case? Again, the Reid bill cuts Medicare to create a new government entitlement program. More specifically, the Reid bill will cut nearly $135 billion from hospitals, $120 billion from Medicare Advantage, and almost $15 billion from nursing homes, more than $40 billion from home health care agencies, and close to $8 billion from hospice providers. How can that be good for our seniors? These cuts will threaten beneficiary access to care, as Medicare providers find it more and more challenging to provide health services to Medicare patients. How can cutting $465 billion, almost $500 billion, out of Medicare strengthen the program? It defies logic. I do not know how people can stand on this floor and make that statement. The people out there have caught on to it. Senior citizens have caught on to it. All across the country they are up in arms, and they should be.

In addition, the proposed legislation permanently cuts all annual Medicare provider payment updates. Hospitals, home health agencies, and hospice facilities would face even more annual reductions over the next 10 years. Advocates of these reductions, known as ''productivity adjustments,'' will argue that today Medicare is overpaying certain providers because current payment updates do not take into account increases in productivity which actually reduce the cost of providing beneficiaries health care services. Come on. To me these permanent productivity adjustments will make it harder for Medicare providers to remain profitable, as Medicare payments fail to keep up with the cost of providing these health care services.

As a result of these payment reductions, I believe many doctors and other Medicare providers will stop seeing Medicare patients. In my home State of Utah, low Medicare reimbursement rates are already a serious problem for beneficiaries and their health care providers. These additional reductions will only make it more difficult. I want to stress to my colleagues that cutting Medicare to pay for a new government program is irresponsible. Any reductions to Medicare should be used to preserve the program, not create a new government bureaucracy or a new entitlement program. I believe it makes more sense to target the Medicare savings towards paying off Medicare's unfunded liabilities or preventing the program's future insolvency.

I wish to take a few minutes to talk about the Medicare Advantage Program and how it is affected by the Reid bill. As I stated previously, the Reid bill reduces Medicare by close to $500 billion. Almost $120 billion comes out of the Medicare Advantage Program. During the Finance Committee's consideration of the Baucus health bill, I offered an amendment to protect extra benefits currently enjoyed by Medicare Advantage beneficiaries. Unfortunately, my amendment was defeated. In other words, the President's pledge assuring Americans that they would not lose benefits was not met by either the Finance Committee bill or the Reid bill currently under consideration in the Senate. Here is how supporters of the Finance Committee bill justified the Medicare Advantage reductions. They argued the extra benefits that would be cut, such as vision care, dental care, reduced hospital deductibles, lower copayments, and premiums, were not statutory benefits offered in the Medicare fee-for-service program. Therefore, these benefits did not count. Well, they counted for the seniors receiving those benefits.

A few weeks back our President once again assured the American people

that they could keep their current health plan. Here is what he said:

> The first thing I want to make clear is that if you are happy with the insurance plan that you have right now, if the costs you're paying and the benefits you're getting are what you want them to be, then you can keep offering that same plan. Nobody will make you change it.

I believe that promise should apply to all Americans, including those participating in the Medicare Advantage Program. Congress is either going to protect existing benefits or not. It is that simple. Unfortunately, under the Reid bill, if you are a beneficiary participating in Medicare Advantage, that promise does not apply to you.

I have some history with the Medicare Advantage Program. I served as a member of the House-Senate conference, as did the distinguished chairman of the Finance Committee. We both served as members of the Senate conference committee which wrote the Medicare Modernization Act of 2003. Among other things, this law created the Medicare Advantage Program. We did it because we wanted to provide health care choices to beneficiaries living in rural America. And it did. Medicare+Choice didn't do it. We knew it wouldn't do it. When conference committee members were negotiating the conference report, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries. At that time there were many parts of the country where Medicare beneficiaries did not have choice in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all government-run health program.

By creating the Medicare Advantage Program, we provided beneficiaries with a choice in coverage and then empowered them to make their own health care decisions as opposed to the Federal Government making those decisions for them. Today every Medicare beneficiary may choose from several health plans for his or her coverage. Medicare Advantage works. It has worked. It will work in the future, if we don't louse it up with this bill.

On the other hand, Medicare+Choice and its predecessors did not, because many plans across the country, especially in rural areas, were reimbursed at very low rates by the Medicare Program. I fear history could repeat itself if we are not careful. Let me take a minute to talk about Medicare+Choice. I represent a State where Medicare managed care plans could not exist due to low reimbursement rates. To address that concern, Congress included language which was signed into law establishing a payment floor for rural areas, but it was not enough. In fact, in Utah all of the Medicare+Choice plans eventually left because they were all operating in the red. This happened after promises were made that Medicare+Choice plans would be reimbursed fairly and that all Medicare beneficiaries would have access to these plans.

So during the Medicare Modernization Act conference, we fixed the problem. First, we renamed the program Medicare Advantage. Second, we increased reimbursement rates so that all Medicare beneficiaries, regardless of where they lived, be it in Fillmore, UT or New York City, had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all government plan. Today Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan. Close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their health coverage. But that could all change should the health care reform legislation currently being considered become law. Choice in coverage has made a difference in the lives of more than 10 million individuals nationwide. The extra benefits I have mentioned are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles. To be clear, the Silver Sneakers program is one that has made a difference in the lives of many seniors, because it encourages them to get out of their home and remain active. It has been helpful to those with serious weight issues, and it has been invaluable to women suffering from osteoporosis and joint problems. In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate this program.

Additionally, these beneficiaries receive other services such as coordinated chronic care management, dental coverage, vision care, and hearing aids.

In conclusion, I cannot support any bill that would jeopardize health care coverage for Medicare beneficiaries. I truly believe that if the bill before the Senate becomes law, Medicare beneficiaries' health care coverage could be in serious trouble. We owe it to the 43 million Americans, seniors and disabled who depend on Medicare, to reject the nonsensical Medicare cuts included in the Reid bill. We must have better solutions that will not hinder their ability to see the doctor of their choice.

I have been in the Senate now for 33 years. I pride myself for being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977.

Let me be clear: I want a health reform bill to pass this Chamber, but I want it to be a bipartisan bill that passes the Senate by 70 to 80 votes. If a bill involving one-sixth of the American economy cannot get 70 to 80 votes, that bill has to be a lousy bill, especially if it is a partisan bill, like this one.

If we could do it in 2003, when we considered the Medicare prescription drug legislation, we can do it today. There has never been a bill of this magnitude affecting so many American lives that has passed this Chamber on a straight party-line vote. In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. The Balanced Budget Act in 1997, which included the Children's Health Insurance Program; the Ryan White Act; the Orphan Drug Act; the Americans with Disabilities Act; and the Hatch-Waxman Act are a few of these success stories, and I was a prime sponsor of every one of those bills. If the Senate passes this bill in its current form with a razor thin margin of 60 votes—or even 61, to be honest with you—it would be so partisan it wouldn't even be funny. This would be yet one more example of the arrogance of power since the Democrats have secured a 60-vote majority in the Senate.

There is a better way to handle health care reform. First and foremost, it must be bipartisan. We stand ready and willing to work on a bipartisan bill, without the restrictions that were placed on the distinguished Senator who chairs the Finance Committee. It should be bipartisan. Second, we cannot erode the existing system that has provided quality and affordable health care to most Americans for decades. While we all agree that the current system should be improved, this bill is certainly not the answer. If the Senate passes the McCain motion to recommit, we can begin to work on a bipartisan health bill that will eliminate the overwhelming Medicare payment reductions and at the same time address the serious issues facing the Medicare Program in the near future.

Look, we know that insurance should cover preexisting conditions. We know if we use 50 State laboratories by giving the States the money to address health care in accordance with their own demographics, not only will states resolve their own health care issues but we also will be able to learn from the successes of these States.

We all know if we address medical liability reform and eliminate approximately 90 percent of the frivolous cases that are filed—costing anywhere from $54 billion to $300 billion a year in unnecessary costs—we know those savings would help us pay for this bill.

We know there are so many things we could do on wellness and prevention that will work. I think all of us agree on most of these issues. Democrats could never agree on medical liability reform because the personal injury lawyers—and there is a limited group in what used to be the American Trial Lawyers Association—are high funders of Democratic races. So they are not willing to do anything about it. In fact, in the House bill, if you do not cooperate with the personal injury lawyers, you lose your money. It is unbelievable.

We know there are a number of other things we could do that both sides could agree on that would cut costs. We are currently spending in this country, without this bill, $2.4 trillion on

health care, all told. This bill will add, over a true 10-year period, another $2.5 trillion to the cost. So it will result in almost $5 trillion in health care spending. Why don't they admit it is going to be at least $2.5 trillion? They do not admit it because for the first 3 or 4 years they count the taxes that are charged, but they do not implement the program until 2014 in the Reid bill. It is 2013 in the House bill, and even 2014 in some aspects of the House bill. That is the only reason they can say it is about $1 trillion. It is actually $2.5 trillion according to figures from the Senate Budget Committee, using the figures of the Congressional Budget Office.

I hate to see $500 billion come out of Medicare, at a time when Medicare is going to go insolvent by 2017 or 2018. I think it is absurd. I think it is ridiculous. I do not blame the seniors for being upset, and they are very upset throughout this country. They have reason to be upset. I urge my colleagues to support the McCain motion to commit this bill, and let's get working on a truly bipartisan bill.

There are some of us who have the reputation of working with the other side in a bipartisan way. We want to do it. We want to get it done. We want the vast majority of the people in this country happy with the final bill. We want to have between 75 and 80 votes, as a minimum, to pass this bill. That way, there would be at least some assurance that it was a bipartisan bill and it might have a real chance to work. But if we pass this bill 60 to 40, let's be honest about it, you know it is a lousy bill.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. CARDIN. Mr. President, first, let me thank the Senator from Montana, Mr. BAUCUS, for bringing forward a bill that has been long overdue on the Senate floor.

This is a historic moment as we debate health care reform. Many of us have been looking forward to this moment for many years. As to this bill, the Congressional Budget Office has now confirmed, for the overwhelming majority of Americans, it will bring down their health care insurance premiums.

This bill will bring down the growth rate of health care costs. It will provide affordable options for millions of Americans who today have been denied the opportunity to buy health insurance.

The Congressional Budget Office tells us that it will insure 31 million Americans who otherwise would not have insurance, bringing down the uninsured rate. And, most importantly, the Congressional Budget Office—that objective scorekeeper; that is not Democrats, not Republicans; this is the objective scorekeeper—tells us this bill will bring down the Federal deficit.

So it is a responsible bill, a bill that will provide affordable insurance options for millions of Americans who are denied insurance today. It will reduce our deficit, and will start to get a handle on the escalating cost of health care. It saves money. It saves lives through prevention and early detection of diseases, and by expanded coverage. And it saves Medicare.

Why does it save Medicare? Because many of us who have been here for a long time understand that the only way you can bring down the cost of Medicare is to bring down the cost of health care. That is exactly what this bill does, providing for the long-term safety of Medicare for our seniors.

It also expands benefits for our seniors in prevention and helps to start to fill the doughnut hole in prescription drug coverage. The underlying bill moves us toward what we need to do in health care reform. It brings down health care costs. How? By managing diseases and understanding the way we pay for diseases today is where most of the cost in health care is. This helps us manage diseases. It expands insurance coverage, which will bring down costs. It provides for investments in health information technology so we can bring down the administrative costs, and it invests in wellness and prevention.

AMENDMENT NO. 2791

Mr. President, I rise today to encourage my colleagues to support the Mikulski amendment, which will ensure women have access to essential preventive services. The leading causes of death for women are heart disease, cancer, and stroke. Early screening for risk factors could prevent many of these deaths and lead to improved health and quality of life for women. But despite the benefits of early screening, many insurers do not cover them, and too often women skip them because the costs are prohibitive. We know early detection of disease saves lives, and so we must ensure that needed preventive services are available to all Americans, regardless of gender.

I have long worked to improve access to preventive services. Knowing what we do now about the importance of prevention, it seems hard to believe that before 1998 Medicare did not cover cancer screenings or other preventive services. I am proud of a bill I authored in 1997 as a Member of the House of Representatives. It established the first package of preventive benefits in traditional Medicare. It was part of the 1997 Balanced Budget Act, and it would not have passed but for strong bipartisan support.

Medicare now covers screenings for breast, colon, and prostate cancer, bone mass measurement for osteoporosis, diabetes testing supplies, glaucoma, and more. Last year's bill, the Medicare Improvements for Patients and Providers Act, gave HHS the authority to expand the list of covered services so that as new, highly effective procedures are discovered, they can be made available to beneficiaries without having to wait the length of time for Congress to act. This bill wisely builds on the benefit package for seniors and expands it to cover all Americans as part of their insurance coverage. We are expanding prevention and making sure it is available so all Americans will have a better insurance product that will cover preventive services.

Basic screenings can have an enormous impact on health and save money in the long run. Chronic disease incurs a huge cost for our health care system. Today, more than half of Americans live with at least one chronic condition, accounting for 75 percent of all health care spending each year. To bend the cost curve, we need to reduce the onset of chronic diseases before they become much more expensive to treat.

The American Cancer Society reports that the incidence of cervical cancer and mortality rates have decreased by 67 percent over the past three decades. This is mainly attributable to the introduction of the Pap test. The average cost for normal cervical screening in 2004 was $31. In contrast, the treatment for early-stage cervical cancer averaged $20,255, and the treatment for late-stage cervical cancer was almost $37,000. Screening saves lives, saves money. The bill before us invests in prevention. It will save money. It will save lives.

Breast cancer screening has also been shown to reduce mortality. Early-stage diagnosis gives a 5-year survival rate of 98 percent, and statistics compiled by the American Cancer Society indicate that 61 percent of breast cancers are diagnosed at this stage, largely due to mammographies and other early screening methods.

The bill before us guarantees coverage for a number of services to promote public health and wellness and to prevent devastating chronic disease. Some of these measures include providing coverage for everyone for services that have an ''A'' or ''B'' rating by the U.S. Preventive Services Task Force. These tests and screenings are either recommended or strongly recommended and include screenings for osteoporosis, colon cancer, and would be covered with no cost sharing—a strong incentive for people taking advantage of these screenings.

Covering immunizations recommended for adults by the Advisory Committee on Immunization Practices of the CDC is also covered. Preventive care services and screenings for infants, children, and adolescents that are supported in comprehensive guidelines from the Health Resources and Services Administration—all that is in the underlying bill that will save us money and will save us lives.

In addition to these vital services, the women's preventive health services must also be covered, the Mikulski amendment. The Mikulski amendment extends the preventive services covered by the bill to those evidence-based services for women that are recommended by the Health Resources

and Services Administration. HRSA, a division of the Department of Health and Human Services, has as its goal to improve access to primary and preventive care services to uninsured and underinsured individuals.

It focuses on maternal and child health, HIV/AIDS care, recruiting doctors in underserved areas, health care in rural areas, and organ donation. HRSA strives to develop ''best practices'' and create uniform standards of care, including eliminating health disparities among minority populations.

Some of the additional services for women that will be covered under the Mikulski amendment include mammograms for women under 50. In 2000, breast cancer was the most common cancer affecting Maryland women, and nearly 800 women died from the disease, according to the Maryland Department of Health and Mental Hygiene. According to the Kaiser Family Foundation, 76.6 percent of women aged 40 and over had a mammography within the past 2 years. This amendment would ensure that all of these women would have access to mammography with no out-of-pocket cost.

Also covered under the Mikulski amendment are cervical cancer screenings for all women, regardless of whether they are sexually active, and ovarian cancer screenings—all those will be made available under the Mikulski amendment. Ovarian cancer is the fifth leading cause of cancer deaths among women in Maryland. General yearly well-women visits would be covered; pelvic examinations, family planning services, pregnancy, and post partum depression screenings, chlamydia screenings for all women over 25. Chlamydia is the most prevalent sexually transmitted disease diagnosed in the United States. Approximately 4 million new cases of this disease occur each year, and up to 40 percent of the women infected with this disease may be unaware of its existence. It is the leading cause of preventable infertility and ectopic pregnancy.

Also included are HIV screenings for all women regardless of exposure to risk. According to the Kaiser Foundation, among those women who are HIV positive, 33 percent of the women were tested for HIV late in their illness and were diagnosed with AIDS within 1 year of testing positive.

We need to do a better job here. This is International Aids Awareness Day. I think it is very appropriate we have the Mikulski amendment on the floor today.

Studies reported by the Kaiser Foundation indicate that women with HIV experience limited access to care and experience disparities in access, relative to men. Women are the fastest growing group of AIDS patients, accounting for 34 percent of all new AIDS cases in 2001, compared with 10 percent in 1985. So this amendment will help in regard to that issue for our women.

Also included is sexually transmitted infection counseling for all women. Women disproportionately bear the long-term consequences of STDs. Screenings for domestic violence are covered. The Maryland Network Against Domestic Violence reports that one out of every four American women—one out of every four American women—reports she has been physically abused by a husband or a boyfriend at some time in her life. Well, the Mikulski amendment provides screenings for domestic violence.

Also included are overweight screenings for teens, gestational diabetes screenings, thyroid screenings.

Much of the debate on health care reform has focused on quality—how do we make our health care system work better and produce better outcomes for the money we spend. Ensuring that women have access to preventive services that are recommended by experts on women's health is absolutely essential to providing quality care.

This amendment protects the rights of a woman to consult with a doctor to determine which services are best for her and guarantees access to these services at no additional cost. Preventive health care initiatives is one area I hoped we could all agree upon. The Senate has a long history of bipartisan support for women's preventive services. I hope the string remains unbroken with this amendment.

I strongly support the efforts spearheaded by Senator MIKULSKI to extend the services that are covered for women. I strongly urge my colleagues to support this very important amendment that makes a good bill better. This bill is desperately needed. Let's vote for those amendments that improve it, such as the Mikulski amendment, and let's move forward with this debate.

With that, I yield the floor.

Mrs. FEINSTEIN. Mr. President, I rise in support of the Mikulski amendment and to discuss the importance of preventive health care for women.

All women should have access to the same affordable preventive health care services as women who serve in Congress.

The Mikulski amendment will ensure that is the case.

It will require plans to cover, at no cost, basic preventive services and screenings for women.

This may include mammograms, pap smears, family planning, and screenings to detect heart disease, diabetes, or postpartum depression—in other words, basic services that are a part of every woman's health care needs at some point in life.

We often like to think of the United States as a world leader in health care, with the best and most efficient system. The facts do not bear this out.

The United States spends more per capita on health care than other industrialized nations but has worse results.

According to the Commonwealth Fund, the United States ranks 15th in ''avoidable mortality.'' This measures how many people in each country survive a potentially fatal, yet treatable medical condition. And the United States lags behind France, Japan, Spain, Sweden, Italy, Australia, Canada, and several other nations.

According to the World Health Organization, the United States ranks 24th in the world in healthy life expectancy. This measures how many years a person can expect to live at full health. The United States again trails Japan, Australia, France, Sweden and many other countries.

These statistics show we are not spending our resources wisely. We are not finding and treating people with conditions that can be controlled.

Part of the answer, without question, is expanding coverage. Too many Americans cannot afford basic health care because they lack basic health insurance.

The Mikulski amendment, and providing affordable access to preventive care, is another part of the answer.

Women need preventive care, screenings, and tests so that potentially serious or fatal illnesses can be found early and treated effectively.

We all know individuals who have benefited from this type of care.

A mammogram identifies breast cancer, before it has spread.

A pap smear finds precancerous cells that can be removed before they progress to cancer and cause serious health problems.

Cholesterol testing or a blood pressure reading suggest that a person might have cardiovascular disease, which can be controlled with medication or lifestyle changes.

This is how health care should work: a problem found early and addressed early. The Mikulski amendment will give more women access to this type of care.

Statistics about life expectancy and avoidable mortality can make it easy to forget that we are talking about real patients and real people who die too young because they lack access to health care.

Physicians for Reproductive Choice and Health shared the following story, which comes from Dr. William Leininger in California.

He states:

> In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship, and she lost her health insurance when they divorced.
>
> For the next five years, she had no health insurance and never received follow-up care (which would have revealed that her cancer had returned). She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread.
>
> She had two children from her previous marriage—her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her kids after her death. She succeeded. She was 28 when she died.

Cases like these explain why the United States trails behind much of

the industrialized world life expectancy. For this woman, divorce meant the loss of her health care coverage, which meant she could not afford follow up care to address her cancer, a type of cancer that is often curable if found early.

This story shows the need to improve our system, so women can still afford health insurance after they divorce or lose their jobs, and it shows why health reform must adequately cover all the preventive services that women need to stay healthy.

I urge my colleagues to join me in supporting the Mikulski amendment.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. BUNNING. Mr. President, is the pending business still the health care reform bill?

The PRESIDING OFFICER. It is, and the motion to commit.

Mr. BUNNING. Mr. President, Republicans and Democrats alike agree that Congress needs to look at ways to reform our health care system. Too many Americans are uninsured, underinsured, or cannot afford the health insurance they have.

Reforming health care, which amounts to over 17 percent of our gross domestic product, is no easy task, and it is a process that should not be rushed. I believe Congress should move in an incremental approach to reforming health care. We are restructuring one-sixth of our national economy with this bill, and we should be darn sure we know what we are doing. I believe Congress should work in a bipartisan way to draft reform legislation instead of working in secret behind closed doors.

I support measures such as passing medical malpractice reform, allowing small businesses to band together to buy insurance, and allowing individuals to buy insurance across State lines. These strategies will help lower costs, make insurance more affordable, and increase coverage. That should be the goal of health care reform, and we can do this without putting Washington bureaucrats and Members of Congress in control of our health care. This seems like a win-win situation to me.

I also support the bill introduced earlier this year by Senators COBURN and BURR called the Patients' Choice Act which reforms the health care system. This bill helps States establish State-based exchanges, helps low-income families with health care costs, and improves health care savings accounts. I have heard members of the majority party claim that Republicans don't have a health care plan. They couldn't be more wrong. We just don't have a 2,000-plus page bill as they do that will drive up premiums, cut Medicare by $½ trillion, and raise taxes on all Americans. We just don't have a bill as they do that costs $2.5 trillion and will threaten the future of our children and grandchildren as they struggle to pay the debts we are leaving them.

I wish to take a few minutes to explain my concerns with the bill that Senator REID has laid out before us. Unfortunately, it is hard to even know where to start. As I said, this bill is over 2,000 pages long. Its table of contents—the table of contents—is 13 pages long. It was written behind closed doors by a small group of handpicked people by the majority leader, so most of us in the Senate, and the American people, had no idea what was in it before it was released. For a majority party that billed itself as being transparent, they certainly failed in writing this bill.

The bill we have before us changes the way health care is delivered in this country. It will affect every American regardless of whether they have insurance, regardless of whether they are satisfied with their insurance, or even if they are on Medicare. We need to make sure we know what we are doing and know what the long-term consequences are of any changes we make. At this point, I am not confident that we do.

This bill will cost $2.5 trillion over 10 years when fully implemented. It raises taxes by almost $½ trillion. It cuts almost $½ trillion from the Medicare Program. Yet it still leaves 24 million people uninsured. The bill jeopardizes the ability of Americans to keep their own doctor and will lead to the rationing of care.

The recent recommendations of the U.S. Preventive Services Task Force on breast cancer screening should be a wakeup call to all Americans about Washington bureaucrats meddling in their health care. Under this bill, health care premiums will rise, 5 million Americans will lose their employer coverage, and 15 million more will be added to Medicaid and the CHIP program. I think this is a move in the wrong direction.

Medicaid often underpays medical providers for treating patients which makes it hard for doctors who want to treat these patients and hard for patients to find doctors to treat them. We should be finding ways to help people better afford private insurance, not simply adding them to the public dole. This bill puts Washington bureaucrats and Members of Congress in control over many aspects of our health care which should scare everyone within the sound of my voice.

For example, starting in 2014, Washington will require most Americans to prove they have health insurance or pay a penalty tax. The penalty will be phased in over a couple of years, but in 2016, the penalty will be $750 per person with a maximum of $2,250 for a family. These amounts are indexed in future years, however, so the penalty will continue to increase.

If you aren't in one of the bill's special exemption categories, you will have to prove that you and your family have insurance when you sit down to fill out your taxes. If you don't, then you will get to send Uncle Sam an additional $750 or $2,250 on April 15.

I know the authors of this bill will try to argue that since their bill leads to nearly universal coverage, most Americans would not be affected by this tax. That couldn't be further from the truth. According to the Congressional Budget Office, the official scorekeeper, this bill leaves 24 million Americans uninsured. Twenty-four million Americans without insurance is not ''universal coverage'' or anything close to it. Also, Members of Congress are going to be telling people what type of insurance they have to buy, and we will not even be giving every American access to the cheapest plan on the market.

The bill requires that only four types of health care insurance can be offered in the exchange: bronze, silver, gold, and platinum. All the plans would have to offer certain benefits and meet certain criteria. However, the bill creates a special catastrophic plan for only special groups of people: those under the age of 30 and those who don't have affordable coverage. It doesn't matter that many more people want this level of coverage. If they aren't under 30 or meet some type of income eligibility test, they are just out of luck.

Catastrophic coverage is the right type of coverage for many different types of Americans, including singles, younger people, and the healthy. It is very likely to be the cheapest plan affordable on the exchange. Think about this: a young woman in her thirties, she eats right, she exercises, doesn't smoke, takes good care of herself. She wants a catastrophic plan, and it is all she needs. Under this bill, she couldn't buy into the catastrophic plan because of her age. Members of Congress tell her she isn't entitled to the cheapest plan on the market because she is too old. She is in her thirties. Or think of the 29-year-old male who has been enrolled in this catastrophic plan in his early twenties. On his next birthday, the Federal Government has a big birthday surprise for him. He will get kicked out of the insurance plan he has enjoyed for years and will be forced to join a more expensive health care plan. That is a wonderful birthday gift.

I don't think Congress's role is to require all Americans to buy insurance. I don't think Washington bureaucrats and elected Members of Congress should be dictating what health care options are available for the entire country.

I understand the importance of insurance. I think everyone should have insurance, but I don't think it is the Federal Government's responsibility to force people to buy it or micromanage what insurance looks like.

This bill also makes huge cuts in Medicare which will affect every senior. The bill cuts—and we have heard it many times today—$465 billion from the Medicare Program. These cuts would not be used to shore up the Medicare Program which will be insolvent in just about 8 years. Instead, these cuts will be used to fund new government spending. This move further jeopardizes the viability of the Medicare Program.

I know AARP and the American Medical Association are trying to tell seniors these cuts will actually be good for the Medicare Program and the program would not be harmed, but let's be honest. When you think about it, does it really make any sense? Congress is going to cut $465 billion from a program that is already facing bankruptcy, and it will somehow make it stronger? If you believe that, I have some oceanfront property to sell you in Arizona.

Under this bill, hospitals will be cut, nursing homes will be cut, health home agencies will be cut, hospices will be cut, and Medicare Advantage programs will be cut. By cutting the reimbursement rate for providers, they are making it harder for seniors to find medical providers to treat them. Plain and simple: Seniors will have the same benefit, but if they cannot find anyone to treat them, then their benefits don't do them any good, do they?

I have to tell my colleagues there isn't one medical provider who walks in my office each year who is happy with their reimbursement rate under Medicare. I cannot think of one. Hospitals are not happy. The doctors are not happy. Hospice care providers who provide such valuable services to dying Americans and their families are not happy. No one is happy.

What do you think is going to happen to these reimbursements when the cuts go into effect? How happy will the providers be then?

Another problem with this bill is the creation of a government plan. I can say I do not support a government-run plan in any form. I have already described the significant problems with Medicare and Medicaid. Creating a new government-run health program will lead to the same sort of problems that plague these plans.

I fear it will eventually undermine private insurance enough so we are left with a single-payer, government-run system. I have been in Congress long enough to know it will be a disaster for this country.

Finally, this bill imposes an unprecedented tax increase on Americans. The tax hikes in this bill would start hitting Americans next year, while the spending and benefits will not start, in many cases, until 2014. That is how the majority is hiding the true cost of the bill—using 10 years of tax hikes to offset 6 years of spending.

Everybody knows tax increases are deadly in a fragile economy. But that is not preventing the majority from pushing through $½ trillion in tax hikes in this bill. In further defiance of logic, these tax increases will actually drive up the cost of health care. I was under the impression the goal of health care reform was to reduce costs, not increase them.

As I mentioned earlier, if you have the misfortune of being uninsured, you will be further punished under this bill by paying a penalty tax. If you are an employer that hires a low-income worker and cannot afford to provide health insurance, you probably will be punished with a penalty tax. If you are an employer that offers retirees prescription drug coverage, your taxes will go up. If you have extremely high medical costs and use itemized deductions for medical expenses to defray your costs, your taxes will go up. If you use a flexible spending account, health reimbursement account or health savings account for over-the-counter medicines, your taxes will go up. If you have a flexible spending account, it will be capped and then probably disappear in a few years because of the high-cost plan tax, so your taxes will go up.

This bill also creates a new marriage penalty in the Medicare payroll tax and uses the money to pay for a brandnew entitlement program. It also imposes a new tax on cosmetic surgery. If a family is forced to liquidate a health savings account because of tough economic times, the government will confiscate even more money.

The bill also imposes new taxes on brand-name drugs, medical devices, and health insurance, all of which will increase health care costs and drive up premiums. Now that the government has succeeded in driving up premiums, the government will hit you again by taxing high-cost insurance policies. It makes perfect sense—drive up the cost of insurance premiums with new taxes and then tax them again for being too costly.

We could have health care reform that reduces health care costs for families and businesses. We could have health care reform that didn't raid $½ trillion from Medicare. We could have health care reform that allows people who like the coverage they have to truly keep it. We could have health care reform that doesn't drastically expand government spending on health care or push people into government programs. We could have health care reform that does not increase taxes on the American people at the worst possible time, during a recession. We could have health care reform that is done in the light of day rather than behind closed doors.

The American people deserve better, and we ought to defeat this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, as I understand it, there are a couple Senators left, besides myself, Senator SESSIONS and Senator BURR. There may be others, but I see them at the moment.

America's health care system is in a crisis. It is a crisis not just for the 46 million Americans who lack health insurance; it is also a crisis for those who have health insurance but are worried they cannot afford to keep it. It is also a crisis for those who are underinsured and those who have poor health insurance.

Rising health care costs affect families and American businesses. That we know. Health insurance premiums continue to outpace wages and inflation by a large margin. Between 1999 and 2008, premiums for employer-sponsored health benefits more than doubled. In that 9-year period, they increased 117 percent for families and individuals, and they increased 119 percent for employers. In each case, both for families and for employers, health insurance premiums doubled. Clearly, that is outpacing wages. I think the margin is 5 or 6 to 1, with premiums going up compared with wages for Americans.

Health care coverage for the average family now costs more than $13,000 a year. If the current trend continues, by 2019, the average family plan will cost more than $30,000. That is over a 10-year period—from $13,000 for the average family today to $30,000 that family will pay then.

Annual health spending growth is expected to continue to outpace average annual growth in the overall economy by 2 percent over the next 10 years. Health care spending is going up faster than the economy is growing. Add to that the insult, frankly, that this year alone not only would health spending increase 5 percent but GDP is expected to decrease two-tenths of a percent. So the gap is widening even further.

Americans spend $4.5 million in health care every minute of every day. Think of that. We, in America, spend about $4.5 million in health care every minute. That is $2.5 trillion a year. It is pretty hard for anybody to get his or hands around 1 trillion, but we are talking about $2.5 trillion that Americans spend on health care every year. Without reform, health care expenditures will increase to $4.4 trillion in just the next 9 years. That would be more than one-fifth of our economy. So health care is taking a bigger and bigger bite out of our economy. These are not just numbers.

Every 30 seconds, another American files for bankruptcy after a serious health problem. Think of that. Every year, about 1.5 million families lose their homes to foreclosure. Why? Because of unaffordable medical costs. In America, nobody should go bankrupt because they are sick. That is immoral.

These numbers tell us what we have to do. We have to do two things at once. First, our health care reform bill must provide health care for millions of Americans who today don't have health insurance. At the same time, we must reduce the rate of growth in health care spending. We must do both. To be successful, health care reform must rein in the cost of health care spending, and we must succeed. Millions of Americans depend on it.

Our plan is to reduce the Federal budget deficit by $130 billion over the next 10 years. Think of that. Many have said an economic recovery is through health care reform. We have to get control of our deficits. One way to do that is to get control of our health care spending. The bill before us now reduces the deficit by $130 billion over the next 10 years.

We need to go much further, clearly, but that reduction is sure a lot better than no reduction. At the same time, our plan would reduce the number of uninsured by 31 million. It would reduce the number of Americans who are uninsured and, at the same time, we will cut the Federal budget deficit. So we are doing both.

This bill reins in costs through changes in spending, reforms how providers deliver health care, and it changes the tax treatment of health care. Savings from this bill are estimated to total $106 billion in 2019. The CBO, Congressional Budget Office, which we all rely upon, expects that, in combination, it would increase 10 to 15 percent in the next decade; that is, savings growth, creative savings would grow by that much. That is what CBO says. That is a strong rate of savings. Those are all provisions to control the excessive growth in health care spending.

Our plan also reevaluates the tax treatment of health care. The current Tax Code includes numerous health care subsidies and incentives. The current tax treatment of certain health care expenses encourages people to spend more on health care than they need to. Why? Because there is no limit under the law, none; that is, all employer-provided health care benefits in America today are totally tax free. The more the benefits are, if a company wanted to provide not only a Cadillac policy but diamond and gold benefits—great benefits—it is not needed tax free. That tends to encourage excessive health care spending. These indirect health care costs totalled nearly $200 billion in 2008. That makes health care the largest Federal tax expenditure. Health care today is the largest Federal tax expenditure. Our laws changed about 60 years ago and moved in that direction, limiting subsidies for expensive insurance plans. Our bill limits incentives to overspend on health care. Our bill will help to slow the growth of health care spending.

Also, the CBO, in a letter they sent to the Congress yesterday, concluded there is about—this provision, the tax on so-called Cadillac plans, would result in a reduction in premiums those persons would otherwise pay—a reduction of, I think, about 5 to 7 percent. There has been a lot of concern in this body and beyond this body that that provision—the Cadillac plan provision—would raise costs for those folks who have those plans. The CBO concluded that the premiums for those kinds of plans would be reduced, I think, by 5 to 7 percent, rather than compared with current law. Several parts of our plan have the effect of reducing costs. I mentioned excess tax on high-cost insurance premiums, and that is a powerful one.

Our plan also caps flexible health savings accounts. It puts a cap on them so it is not unlimited. There is no cap, so the Tax Code tends to encourage excessive use of that provision.

Our plan would also conform with the definition of qualified medical expenses, the definition used by the itemized deduction for medical expenses. That, too, will help.

Reducing existing tax expenditures for health care costs is one of the best ways to slow the growth of health care spending. We could use our code, all the tools available. Our goal is not only to reduce costs but also improve quality. There are many provisions in the bill that accomplish that result, which would improve the quality of health care. A lot of people hear us talk about how costly health care in America is today. It is costly—too costly. There is a lot of waste. We are enacting provisions to cut out the waste.

I sense some Americans are thinking: Gee, maybe they are going to cut my Medicare benefits and reduce the quality back there in Washington, where they are worried about excessive health care costs. The exact opposite is the case. All the provisions in here enhance the quality of health care. The list is very long. One that immediately comes to mind is additional spending for primary care doctors. We all know they are underpaid in America. They are not taking Medicare patients, and they are going out of practice, especially in rural areas. This legislation adds 10 percent additional payment to primary care doctors in each of the next 5 years. That will help primary care doctors continue to practice.

I might mention that health information technology will also help improve quality. There are lots of demonstration projects and pilot projects to improve quality through bundling, care organizations, reining in excessive readmission rates some hospitals have. We also have an outfit that compares how drugs work compared with other procedures. All that is going to help address quality.

I want folks to know that while we are reducing costs—that is true because costs have to be reduced—we are also increasing the quality of health care in America. There are many other incentives in this bill that I don't have time to mention tonight that accomplish that result.

In response to the excise tax on high-cost insurance, insurance companies will offer lower cost plans that fall under the thresholds. I think that is one of the reasons why premiums for those folks will fall. This will give consumers a lower cost alternative. These plans will still have the minimum level of benefits that will be required by law under the health care system.

Other changes to the tax treatment of health expenses will also help individuals make more cost-effective health care decisions. For example, our plan would require employers to tell their employees the value of their health insurance.

That reminds me two of the other provisions for increasing transparency so hospitals tell people what they charge for various procedures. I think the same should also apply to physicians so people have a better idea what they will pay or their insurance company will pay for these procedures.

As I said, our plan will require employers to tell their employees the value of their health insurance. This will help people to know how much they are actually spending.

I mentioned changes to flexible savings accounts, health savings accounts, and the definition of ''medical expenses.'' That will all help. It will also help to reduce costs by increasing competition. That has not been mentioned enough on the floor. This bill increases competition. We all know that in too many of our States, there are too few health insurance companies. In my State of Montana, Blue Cross/Blue Shield provides at least half the market. There is another company that is basically the rest. In some States, Blue Cross has the entire market. It is wrong. There is not enough competition. The exchange we are putting in place will encourage competition.

Do you know what else will encourage competition? That is all the insurance market reforms—all of them—telling companies they cannot deny coverage based on a preexisting condition, telling companies they cannot rate according to health status, dealing with rules in the States, which means when you go to buy insurances—especially as an individual—there will be competition based on price. Companies will basically offer many of the same products, but they cannot deny coverage for preexisting conditions. The effect of that will be prices should come down because there will be more competition when insurance companies base it on price.

Then there is the public option. That is another addition. That is in this bill. We don't know if it will or not. There are a lot of ways we help provide competition. It will help more competition, and transparency will help more competition. Competition is going to help bring down the costs.

Our bill will reduce costs also by reforming health care delivery system—I mentioned a lot of that already—including how we pay for doctors.

The bill is balanced. It finds savings in health care outlays—savings that are realistic, that make sense. It looks to reduce health tax expenditures. That is a fancy term for deductions. The bill reduces the Federal deficit in the first 10 years. That point needs to be driven home. This bill reduces the Federal deficit in the first 10 years and the subsequent 10 years will have a positive effect bringing down the budget deficit. In fact, CBO says the second 10 years of our plan will cut the deficit by a quarter of a percent of the gross domestic product. That is about $450 billion. That is nearly $½ trillion in deficit reduction.

We need to remember the cost of doing nothing is unacceptable. Basically, we have two choices in life: try

or do nothing. To ask the question is to answer it. Of course, we tried. Our Nation is in crisis. We have a health care crisis. It is a formidable task. It is exceedingly complex and difficult. But we have an obligation to try, at least try, to fix it.

If we try, then that poses a second question. If we try, we ask the question: Do we try our best or not? The answer is obvious: We try our best.

This legislation is a combination of a year or two of work by folks in the medical profession, of health care economists—Americans who are trying to find ways to get control of costs and improve quality. There are not a lot of new ideas here. They are ideas that have been percolating around for the last year or two. Some are in Massachusetts, some in other States. Some of it is going into integrated systems, such as Geisinger and Intermountain. The idea of bundling is already practiced by other institutions. There is not a lot that is terribly new.

We are pulling together, we are helping establish a policy in our country that comes up with a plan, a system in America that allows doctors and patients to have total free choice. They choose. We are helping doctors with the best evidence, the best information so they can focus on the patient care even more than they are now. We are cutting down the budget deficits. That is very important. And we are also helping Medicare by extending the solvency of Medicare another 5 years. These are things we pulled together and have to do.

I very much hope we can move on and get this legislation passed and work with the House and the President signs a bill that we can start finally putting together something of which we will be very proud. Our country does not have a health care system today. It is a free-for-all. It is a free-for-all for all kinds of groups. This is the first effort to get something together that works, giving doctors and hospitals and patients the choice they want to have and they should have. We are also bringing costs down and improving quality of health care.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I appreciate the statement of the chairman of the Finance Committee. It is one of the most well-reasoned statements we have had. And rightfully so. No one worked harder on this matter than Senator BAUCUS. I appreciate his dedication, hard work, and the way he handles that Finance Committee.

Mr. President, I ask unanimous consent that the time until 2:15 p.m. tomorrow, Wednesday, December 2, be for debate with respect to the pending Mikulski amendment and the McCain motion to commit; that during this period, Senator REID or his designee be recognized to offer an amendment as a side-by-side to the McCain motion, and Senator MURKOWSKI or her designee be recognized to offer an amendment as a side-by-side to the Mikulski amendment; that the debate time be divided equally among the four principals listed above; that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 2:15 p.m. tomorrow, the Senate proceed to vote in relation to the above noted in the following order; that prior to each vote there be 2 minutes of debate equally divided and controlled in the usual form, and after the first vote, the remaining votes in the sequence be 10 minutes in duration; further, that all amendments and motion provided under this consent require an affirmative 60-vote threshold for adoption, and that if those included in the agreement do not achieve that threshold, then the amendments and motion be withdrawn:

Mikulski amendment No. 2791; Murkowski amendment regarding preventive care; Reid or designee amendment regarding Medicare; McCain motion to commit regarding Medicare.

Mr. President, before I put this to a final consent request, let me say, we have been trying to get some votes today. It would be very good if we could move this bill along, have some votes tomorrow afternoon. We would have four votes. We have two amendments pending. This, in fact, would dispose of those amendments.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object, and I will have to object, I wish to say to my good friend, the majority leader, I thought over the last couple of hours we would be able to get consent to have votes on the Mikulski and Murkowski amendments. But I had indicated to him, and I want to say publicly, that we have a number of speakers interested in speaking on the Medicare issue and the McCain motion. So I will not be able to lock in the McCain motion or the side-by-side that I gather under this consent request my good friend, the majority leader, may offer.

I would still like to be able to get the two votes earlier referred to—the Mikulski and Murkowski amendments—but regretfully I cannot even lock those in right now. But I want to do that as soon as possible so at least we can get those two votes at some point reasonably early in the day and turn back to debate on the McCain motion.

I might say, we want to vote on the McCain motion. We certainly have no desire to delay that vote. But we do have a number of people who want to speak to it. With that understanding and with the point I want to make to my good friend that I want to get the two amendments by MIKULSKI and MURKOWSKI locked in as soon as possible, I must object.

The PRESIDING OFFICER (Mr. UDALL of Colorado). Objection is heard.

The Senator from Alabama.

Mr. SESSIONS. Mr. President, I wish to share a few thoughts as we go forward on the health care debate and remind our colleagues what we have been hearing at the town meetings that most of us have been having around the country and what people are concerned about.

Part of it is they think we don't have a very good perspective on what is going on in America. They are not happy with us. They think we are losing our fiscal minds, that we are ignoring the fact that we are facing a soaring debt. We passed on top of the debt we already had an $800 billion stimulus package—$800 billion—the largest spending bill in the history of America on top of all our other baseline bills.

Our baseline appropriations bills, not even including the additions by the stimulus, are showing double-digit increases. These increases are far more than President Bush ever had, and he was criticized for reckless spending. He never had the kind of baseline spending increases that were passed a few months ago, a few weeks ago in some cases.

This year, as of September 30, we acknowledged and accounted for a $1.4 trillion budget deficit in 1 year—1 year, $1.4 trillion, September 30. The Republicans never had a deficit so large in 1 year. And in the next year, it is projected to be over $1 trillion, and continue to average $1 trillion each year over the next 10 years. In the 8th, 9th, and 10th years of the President's 10-year budget, the deficit goes up. It does not ever go down, it continues to go up. Therefore, we end up with a huge debt. That is according to our own Congressional Budget Office hired by the Congress—approved by the majority of our colleagues who are, of course, Democrats. They approve the Budget Director, and he tries to do a pretty good job of giving us honest numbers.

This is what the numbers show. In 2008, we had $5.8 trillion in debt in America since the founding of the Republic. By 2013, 5 years down the road, that will double to $11.8 trillion. And in 10 years, the 10-year budget the President submitted to us—I did not submit this budget, President Obama submitted it and it was passed by the Congress—increases that debt to $17.3 trillion, tripling the debt of America in 10 years. That is what the people are very concerned about, among other things.

What does all this pending mean also? It means government power, government reach, government domination, government takeover. People are concerned about it. They are asking: Are you not getting the message? What is the matter with you? That is what I am hearing. I think people have a right to be concerned.

One of the issues I have raised is the fact that the interest on the debt in 2009 was $170 billion for 1 year—that is for interest alone. By 2019, interest on the debt, according to CBO, in 1 year, will be $799 billion. That number is higher than the budget for defense. It is larger than any other program. We

spend about $100 billion a year on education, and $40 or so billion on highways. But in 10 years, we will be spending $800 billion on interest alone. And how much of that is owned by foreign governments, many of whom are not our friends and not our allies?

So even the President has said this debt is unsustainable. The economists say it is unsustainable. Every politician I know of says that it is unsustainable. Yet we continue outrageous spending, and in the midst of this financial tempest, what do we now have before us? The promise of a $2.5 trillion new health care program—$2.5 trillion as it will cost when fully implemented.

The question I have heard asked of the President, and I have heard asked of the Democratic leadership and the Congress: But, Congressman, Senator, we don't have the money. What do you say about that?

They say: Oh, don't worry. We have this great new program that is going to help you in so many ways. We are going to spend a lot of money, true, but it is going to be deficit neutral. My goodness, it is not even going to be budget neutral, it is going to save us $130 billion in 10 years. Will you guys just relax? Don't worry about it. We are going to save $130 billion. Thank us. We are going to give you this program, save $130 billion, and you will get a lot more health care out here—still with 24 million uninsured, but we will have a lot of money spent to help you with your health insurance, they will say.

The President said he would not sign a bill into law that would add one single dime to the national debt. Well, people say: How are you going to do that? That sounds pretty good, if we can make that happen. How are we going to do it? Well, the answer is we are going to raid Medicare, we are going to raise taxes, and we are not going to pay the doctors who do our work. There will be $494 billion in tax increases, $465 billion in Medicare cuts—and Medicare is already on a glide path to insolvency by 2017—and a $250 billion shortfall for our physicians. Those are payments they have been promised and they thought they were going to get as part of this fix.

So I would just make the point that we can give everyone in America a new car if we just raised taxes and raided Medicare. That would be pretty easy, wouldn't it? Anything can count as deficit-neutral if you raise taxes high enough. So this is not a deficit-neutral program. Just because we raise taxes, does it have to be that we should prioritize first to use that money to start a new program? What about addressing the shortfall in highway funding that we are hearing so much about? What about the cost of our effort in Afghanistan? What about other expenses we have? What about saving Medicare, a program our seniors depend on? If we are going to raise taxes, why don't we use the money for that? Who says we have to raise taxes to start a new program?

Well, I suggest to you that based on the omission of doctors fix alone we don't have a $130 billion surplus in this bill. The fact that it is unpaid for, we have a $130 billion net deficit because the bill fails to pay $250 billion in doctor fees that I predict we will eventually pay, one way or another. The way we have done it in the past is we have just socked it to the debt. We have just paid the doctors, raised no revenue, and changed the law. We have just paid them and increased our debt that much each year.

So I say these are not sound numbers. I am telling you, the American people's instincts are right about this. We are not being responsible about how we manage the people's business, promising that this bill is going to be better for everybody. But let me ask for the average American who is doing the right thing, who is struggling and scraping together money to make insurance premiums each month, will that person pay less for their health care? CBO basically says no. If that individual is not in an employer-provided group plan already, if he's among those who are already paying the highest costs for health care in the country, then he is one of the people who are going to pay as much as 10 to 13 percent more under this bill than he currently pays.

Will health care, as a percentage of our total economy, our total GDP, will it be reduced by this bill, therefore getting more health care at a better cost? Not according to the scoring we have seen. In fact, just the opposite is the case. If this bill passes, a larger percentage of our GDP will go to health care than before.

So I just raise concerns. This is a plan to create an entirely new government-dominated health care plan. This is a new program. How are we going to do it? By raiding Medicare, raising taxes, and not paying doctors, among a bunch of other flimflammery that is in the bill. We talk about this public option. Well, Senator BAUCUS says we may not have a public option. It is in the House bill, and it is in this bill that is on the Senate floor.

So we don't have the money for a monumental new health care program. We could do a lot of things to improve health care in America that could help contain the rising cost of health care, that could be done in a way that would not diminish the circumstances we are in today. What about Medicare? Do you remember when President Bush proposed fixing Social Security and many Senators—Democrats as well as Republicans—said: Well, President Bush, if you want to do something, why don't you fix Medicare? That is the one in the biggest trouble?

In truth, Medicare is sinking faster than Social Security. Medicare will decline by 2017 and go into deficit. We have a shortfall in Medicare now. What we should do is focus on Medicare every way that we can to create efficiencies and more productivity, contain growth and cost and extend that period of time before it goes in default. The last thing we should be doing is taking $465 billion from Medicare. It is only going to accelerate its decline. That is common sense.

Mr. President, I would just like to read a letter I received from one of my constituents—Mr. Bill Eberle in Huntsville, AL. He said:

> I strongly urge you to vote against the health care bill passed by the House. The worst part of this bill is that much of the cost will be paid by cuts to Medicare. I am 68 years old, and I have paid into Medicare for 40 years believing that it would cover much of my health care costs when I became 65. Now I am being told that the government has found people who need coverage more than I do, and they will cut the care for which I have paid for 40 years in order to cover people who have paid nothing. It is not the government's money. The money belongs to those of us who have paid into it for so many years and we are watching as it is being taken from us.

Well, I think that is a pretty fair statement of it. Medicare is heading to insolvency in 2017. We have had a number of proposals to try to help on that front. We haven't had much support from our colleagues on the other side of the aisle even for modest fixes.

I remember one bill that was going to reduce Medicare spending by $10 billion over 5 years, and you would have thought we were going to savage the whole program, although we were trying to make it more sustainable in the long run. It was a big mess. But now we are talking about $465 billion being taken from Medicare.

So, Mr. President, Medicare is a big problem. We need to work hard to bring it under control and honor our seniors who have been paying into this program and not drawing a dime from it on the promise that when they turned 65 they would start being able to draw on Medicare and it would take care of their health care needs in their senior years. That was a solemn commitment. Before we start some monumental new program, we need to make sure we are prepared to honor that commitment because they paid their money. They have paid their money. So if we raise taxes, why shouldn't we pay the Medicare bill first? If we raise taxes, why shouldn't we pay our doctors the money we owe them or some of the other priorities that we have in our country?

Mr. President, I feel strongly that the American people are sending us the right message. They are acting like good public-minded citizens would. They are seeing a reckless new spending program that they rightly anticipate will grow and grow and grow and expand far beyond all the projections we have today; that it will result in a government takeover of a whole large portion of our economy, and they have not been impressed that the government can run these kinds of things very effectively and they are not in

favor of it. So they are rightly concerned, and that is why polling numbers show the American people don't favor this legislation.

I think their instincts are right. I think we should listen to them.

I appreciate the effort to improve health care in America. I support a number of reform provisions, some of which are in this bill, but others could be a part of this bill to make health care more affordable, more effective, and help people who are having a hard time financing their insurance premiums. But the truth is, the bill doesn't really reduce the premium cost for most people. Many people who are paying their bills today are not going to get any reduction. In fact, they may see an increase. So for these reasons, I oppose the legislation, I thank the Presiding Officer, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I believe Senator DURBIN may be coming to the floor. In the meantime, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mr. DURBIN. Mr. President, today, all day, we have been debating the health care reform bill, which has been a matter worked on in the Senate and the House for a solid year. I wish to salute the Senator from Wyoming, Mr. ENZI, who joined with several other Senators in, I understand, 61 separate meetings talking about this bill, in an effort which did not bear fruit as they hoped but was a bipartisan effort to come up with some solution to our health care situation in America. I hope we can still reach some bipartisan accommodation before this bill passes.

At this point in time, only one Republican Senator has voted for any form of Senate health care reform and that was Senator SNOWE in the Senate Finance Committee. We hope others will join us before this bill comes to final passage in the Senate, but that is the reality of the political situation.

The bill before us is over 2,000 pages long. Some have criticized its length. I defy anyone to write down, in 2,000 pages or less, a description of the current medical system in America. I think it would take many more pages to explain the complexity of the situation. But people across America understand a few basics.

Health insurance is reaching the point where it is not affordable. Families cannot afford to pay for it anymore, businesses cannot. Fewer people have coverage at their workplace, and many who go out into the open market cannot afford to pay the premiums. Today we have reached a point where our COBRA plan, which is health insurance for those who have lost their job—we provided a helping hand to many unemployed people across America—it expired today. It picked up two-thirds of the premiums. I ran into people who said, even with the two-thirds picked up by the Federal Government, I still cannot afford it. So it is understandable that health insurance is no longer affordable, and it is not getting any better.

In the last 10 years, health insurance premiums have gone up 131 percent. We estimate that, in the next 8 years, the cost of health insurance will double. In 8 years, it is anticipated that families will spend up to 45 percent of their income on health insurance. That is not sustainable.

So the starting point is to find ways to bring down cost. The Congressional Budget Office gave us a report yesterday and said we are on the right track. I can come up with other ideas which I think might be more helpful, but this is the art of the possible. I think we are moving toward a model which will start to bring down costs.

The second thing we do that is critically important is, we expand coverage so it reaches 94 percent of Americans. Currently, there are about 50 million Americans without health insurance. These are people who are unemployed, folks who work at businesses that cannot afford health insurance or folks out on their own who cannot afford to pay for their own health insurance. We now reach a point with this bill where 94 percent of Americans have coverage. That is a good thing.

We also do it in a fiscally responsible way because this bill, according to the Congressional Budget Office, which is the neutral referee in this battle, according to that office, we will save, in the first 10 years of this bill, $130 billion or more from our deficit. It will be the biggest deficit reduction of any bill considered by Congress. In the second 10 years, they estimate $650 billion in savings. To think we have $¾ trillion dollars in deficit reduction in this health care reform says to me, in the eyes of the Congressional Budget Office and most observers, it is a fiscally responsible bill.

There is a section of the bill which I think is critically important too. Many people with health insurance find out that when they need it the most it is not there. The health insurance companies will deny coverage, saying they are dealing with preexisting conditions that were not covered, there is a cap on the amount they will pay, your child is now age 24 and is not covered by your family plan. All these things are excuses for health insurance companies to say no. When they say no, they make more money. We start eliminating, one by one, these perverse incentives for health insurance companies to say no.

We give consumers and families across America a fighting chance, when they actually need health insurance, that it will be there. Two out of three people filing for bankruptcy today in America file because of medical bills. That reflects the reality, that we are each one accident or one diagnosis away from a medical bill that could wipe out our life savings. The sad reality is 74 percent of people filing for bankruptcy because of health care bills have health insurance, and it turns out it is not worth anything. When they needed it, it failed them.

We need to move to a point where the health insurance companies are held accountable, where when you pay premiums for a lifetime, the policy is there to cover you when you need it. That is what this is about.

We eliminate some of the most egregious discrimination in insurance premiums. The insurance industry is one of two businesses in America exempt from antitrust laws. So they literally get together, they collude and conspire when it comes to setting premium costs and allocating markets, and they can do it legally under the McCarran-Ferguson Act. Because of that, what they have done is to create discrimination against some people—women, certain age groups, people living in certain places—when it comes to premiums. We eliminate, by and large—not completely but by and large—this type of discrimination.

The other point that has been raised repeatedly is about Medicare. There is a pending amendment by Senator MCCAIN. As a Democrat, we take great pride in Medicare. It was a Democratic President, Lyndon Baines Johnson, who led a Democratic Congress in passing it. Very few, if any, Republicans supported it. Over the years, it has been a program we have stood behind as a party because we believe it has provided so much well-being for 45 million American, now today, seniors.

This bill starts to move us toward a place where you can basically say there is a sound economic footing for Medicare in the future. If we don't do something today, in 7, 8, or 9 years, the Medicare Program could go bankrupt. If we wait 5 years to do it, imagine what we will have to do then.

This bill moves in the direction of making Medicare more sound by eliminating some of the waste that is currently in the program.

There was a time when our friends on the other side joined us in saying this program could be more efficient. But now the McCain amendment says basically there should be no cuts in Medicare, even if the cut is in wasteful spending. Senator MCCAIN has a strong record on the Patients' Bill of Rights, but I think his amendment goes too far when it comes to Medicare. I hope that we can defeat it or that he will reconsider it.

The last point I want to make is that this debate will continue. We hope to move to amendments. If we get to a point where we are dealing with filibusters and slowdowns in an effort to run out the clock and make us all leave on Christmas Eve with the job not finished, many of us are going to get tired

of that approach. If there are honest amendments offered in good faith, debated, and brought for a vote, that is what the Senate is about. But if we continue to delay indefinitely the consideration of these amendments, our patience will grow thin, and we will have to move this toward a point where the bill is honestly considered.

FURTHER CHANGES TO S. CON. RES. 13

Mr. CONRAD. Mr. President, section 301 of S. Con. Res. 13, the 2010 budget resolution, permits the chairman of the Senate Budget Committee to adjust the allocations of a committee or committees, aggregates, and other appropriate levels and limits in the resolution, and make adjustments to the pay-as-you-go scorecard, for legislation that is deficit-neutral over 11 years, reduces excess cost growth in health care spending, is fiscally responsible over the long term, and fulfills at least one of eight other conditions listed in the reserve fund.

I have already made one adjustment pursuant to section 301(a) on November 21, for S.A. 2786, the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590. I now file further changes to S. Con. Res. 13 pursuant to section 301(a) for S.A. 2791, an amendment to clarify provisions relating to first dollar coverage for preventive services for women. I find that that in conjunction with S.A. 2786, this amendment also satisfies the conditions of the deficit-neutral reserve fund to transform and modernize American's health care system. Therefore, pursuant to section 301(a), I am further revising the aggregates in the 2010 budget resolution, as well as the allocation to the Senate Finance Committee.

I ask unanimous consent to have the following revisions to S. Con. Res. 13 printed in the RECORD.

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

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2009–	1,532.579
FY 2010–	1,623.888
FY 2011 –	1,944.811
FY 2012 –	2,145.815
FY 2013–	2,322.897
FY 2014	2,560.448
(1)(B) Change in Federal Revenues:	
FY 2009–	0.008
FY 2010–	–42.098
FY 2011 –	–143.820
FY 2012 –	–214.578
FY 2013–	–192.440
FY 2014	–73.210
(2) New Budget Authority:	
FY 2009	3,675.736
FY 2010–	2,910.707
FY 2011 –	2,842.766

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM—Continued

[In billions of dollars]

FY 2012 –	2,829.808
FY 2013 –	2,983.128
FY 2014–	3,193.887
(3) Budget Outlays:	
FY 2009	3,358.952
FY 2010–	3,021.741
FY 2011 –	2,966.921
FY 2012 –	2,863.655
FY 2013 –	2,989.852
FY 2014 –	3,179.437

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

[In millions of dollars]

Current Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays —	1,166,970
FY 2010 Budget Authority —	1,249,836
FY 2010 Outlays —	1,249,342
FY 2010–2014 Budget Authority –	6,824,797
FY 2010–2014 Outlays —	6,818,905
Adjustments:	
FY 2009 Budget Authority	0
FY 2009 Outlays —	0
FY 2010 Budget Authority —	0
FY 2010 Outlays –	0
FY 2010–2014 Budget Authority –	20
FY 2010–2014 Outlays —	20
Revised Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays —	1,166,970
FY 2010 Budget Authority –	1,249,836
FY 2010 Outlays —	1,249,342
FY 2010–2014 Budget Authority –	6,824,817
FY 2010–2014 Outlays —	6,818,925

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

CARTAGENA LANDMINE BAN TREATY REVIEW CONFERENCE

Mr. LEAHY. Mr. President, I want to speak briefly on a subject that many Members of Congress—Democrats and Republicans—have had an abiding interest in over the years.

Throughout this week, delegates from countries around the world will gather in Cartagena, Colombia, to participate in the Second Review Conference of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction.

The Cartagena review conference would have been the perfect opportunity for the Obama administration to announce its intention to join the 156 other nations that are parties to the treaty, including our coalition allies in Iraq and Afghanistan.

In fact, every member of NATO and every country in our hemisphere, except Cuba, is a party to the treaty. The United States is one of only 37 countries that have not joined, along with Russia and China.

By announcing our intention to join the treaty in Cartagena, this administration would have signaled to the rest of the world that the United States is finally showing the leadership that has been wanting on these indiscriminate weapons that maim and kill thousands of innocent people every year.

The U.S. military is the most powerful in the world. Yet we have seen how civilian casualties in Afghanistan have become one of the most urgent and pressing concerns of our military commanders, where bombs that missed their targets and other mistakes have turned the populace against us.

Despite this, one of the arguments the Pentagon makes for resisting calls to join the Mine Ban Treaty is to preserve its option to use landmines in Afghanistan, even though we have not used these indiscriminate weapons since 1991.

Since the Pentagon has never voluntarily given up any weapon, including poison gas, which President Woodrow Wilson renounced in 1925, perhaps this is to be expected.

But can anyone imagine the United States using landmines in Afghanistan, a country where more civilians have been killed or horribly injured from mines than any other in history?

A country which, like our coalition partners, is itself a party to the treaty?

A country where if we used mines and civilians were killed or injured the public outcry in Afghanistan and around the world would be deafening?

Can anyone imagine this President, who has been awarded the Nobel Peace Prize which only a few years ago was awarded to the International Campaign to Ban Landmines, having to publicly defend such a decision?

I wonder if anyone at the Pentagon has thought of the military and political implications of that.

Last Tuesday, the State Department spokesman announced that the administration had completed a review on its landmine policy and had decided to continue supporting the Bush administration's policy, which was, in key aspects, a retreat from the policy of President Clinton.

This was a surprise to me and others, as I had encouraged the administration to conduct such a review and then heard nothing for months. In fact, I had spoken personally with President Obama about it just a few weeks before.

I did not hesitate to express my disappointment, as did many others. Thereafter the State Department corrected itself, and announced that a ''comprehensive review'' is continuing and reaffirmed its earlier decision to send a team of observers to the Cartagena review conference this week.

It is unfortunate that the State Department spokesman misspoke. However, the administration's approach to

this issue until this past weekend had been cursory, half-hearted, and deeply disappointing to those of us who expected a serious, thorough reexamination of this issue.

One hopes that an administration that portrays itself as a global leader on issues of humanitarian law and arms control recognizes this is an opportunity.

A serious review should begin by examining the extensive history of the negotiations that led to the treaty, and the technical issues that were debated and addressed.

It should involve consulting our allies, like Great Britain and Canada, whose militaries have operated in accordance with the treaty's obligations for a decade, including with our forces in Iraq and Afghanistan, to determine what their experience has been.

It should involve consulting with the Pentagon, of course, but also with retired senior U.S. military officers and diplomats, many of whom have expressed support for the treaty.

It should involve consulting with Members of Congress, and with the humanitarian and arms control communities who have extensive expertise on all aspects of the treaty and its implementation.

Unfortunately, none of these obvious steps was taken. Instead, an opaque process involving limited consultations with the Pentagon simply resulted in a regurgitation of the Bush administration's talking points.

That is not what we expected of this administration, and I welcome the announcement that a comprehensive review will be carried out.

The United States has not exported anti-personnel mines since 1992.

We have not produced anti-personnel mines since 1997.

And the United States has not used anti-personnel mines since 1991—when many of them malfunctioned.

In effect, we have been in de facto compliance with the treaty for 18 years, with the exception of not yet destroying our stockpile of mines.

And in the interim we have invested millions of dollars to develop alternatives to indiscriminate landmines, to replace them with munitions that include man-in-the-loop technology, so they are not victim-activated.

Indiscriminate landmines, whether persistent mines or those that are designed to self-destruct or deactivate, are nothing more than booby traps. They cannot distinguish between an enemy combatant, a U.S. soldier, a young child, or a woman out collecting firewood. They do not belong in the arsenal of any modern military.

I have supported President Obama and I look forward to supporting him on many issues in the future. I believe this can be one of those issues.

I am confident that after a proper review is conducted, and the President considers the equities, he will conclude, as our allies have, that the humanitarian benefits of banning anti-personnel landmines far exceed their limited military utility. Ultimately, this is a decision President Obama will need to make himself, as President Wilson did almost a century ago.

I want to commend the Government of Colombia, a country where landmines have taken and continue to take a terrible toll on civilians, for hosting the review conference. Colombia joined the treaty years ago.

I also appreciate that the State Department has sent a team of observers to Cartagena. I hope they use this opportunity not only to highlight the hundreds of millions of dollars the U.S. has provided for humanitarian demining and assistance for mine victims over the years, but also to learn from the delegations of countries that are parties to the treaty.

I want to pay tribute to the leadership of Canada, and my friend Lloyd Axworthy, who as Foreign Minister showed the extraordinary vision and leadership that culminated in the Mine Ban Treaty, and to the other nations that have joined since then.

The treaty has already exceeded the expectations of even its strongest advocates. The number of mine casualties has decreased significantly. The number of countries producing and exporting mines has plummeted.

And at the same time, none of the arguments of the treaty's naysayers have come to pass.

The United States is the most powerful nation on Earth. We don't need these indiscriminate weapons any more than our allies who have abandoned them.

We have not used landmines for many years. We should be leading this effort, not sitting on the sidelines.

It is time for the United States to join the right side of history.

ANTI-KLEPTOCRACY

Mr. LEAHY. Mr. President, on November 16, 2009, the New York Times published an article entitled ''A U.S. Visa, Shouts of Corruption, Barrels of Oil,'' that describes corruption in Equatorial Guinea, which is a major oil producing country. Specifically, the article highlights the comings and goings of Teodoro Obiang, son of Equatorial Guinea's President, who is also the country's agriculture minister.

Mr. Obiang has been a regular traveler to southern California, where he owns an estate reportedly worth some $35 million. He also, according to the article, owns a private jet and various luxury automobiles.

How, one might ask, did he acquire such extraordinary wealth, in a country where many children die before the age of 5? Perhaps he is an exceptionally talented businessman, as Equatorial Guinea's Washington lobbyists have suggested, who, when he isn't running the agriculture ministry on a modest government salary, is earning huge profits that can be legitimately explained. It is fair to say that at least, and probably more, likely is that he has used his family connections to steer a portion of the country's oil revenues into his own pockets.

Mr. Obiang's case is not unique. To the contrary, it is a common practice in countries where the extraction of natural resources—whether oil, gas, timber, or minerals—is the primary source of income. From Angola to Kazakhstan, government officials and their families have abused their power and influence to enrich themselves by siphoning off a portion of the proceeds of the revenues from concessions and leases for the extraction of natural resources, and from the sale of the crude oil or raw timber or minerals.

Billions of dollars that could otherwise have been used to meet the basic needs of the people in these countries—health and education—have instead gone into foreign bank accounts, including in the United States. The beneficiaries have enjoyed lives of comfort and privilege, while their people live in squalor.

The land where oil is drilled, or where gold, cobalt, columbite-tantalite, and other valuable minerals are mined, or where the forest is cut down, is often left in ruins. Soil and water poisoned by oil spills and other toxic chemicals, and drought from deforestation, is left for those who have nowhere else to live, and for future generations.

It is often also the revenues from the exploitation of natural resources that fund the purchase of weapons that fuel civil wars over control of those same resources in these counties. The protracted conflict in the eastern region of the Democratic Republic of the Congo, where thousands of civilians, and particularly women and girls, have been brutalized, is a prime example.

Those who have protested this type of corruption, environmental destruction and waste, and exposed the theft by government officials of income from natural resources that is rightfully owed to the people of these countries, have often been harassed, arrested, tortured, and even killed. I remember Ken Saro-Wiwa, who courageously led peaceful protests against the environmental devastation caused by oil spills and gas flaring in Nigeria's delta region. He was ultimately hanged, despite last minute appeals from people around the world, by the corrupt and cruel dictator Sani Abacha. That was in 1995, but the corruption, waste, and abuses continue today in countries where too often the rule of law does not apply to those in power.

In 2004, President Bush issued Presidential Proclamation 7750, which suspended entry to the U.S. of current and former public officials whose corrupt acts have or had serious adverse effects on the national interests of the United States.

In 2007, I included a similar but more targeted provision in the State and Foreign Operations Appropriations Act, currently section 7086 of Public

Law 111–8, which requires the Secretary of State to deny admission to the United States to any foreign government official and their immediate family members who the Secretary has credible evidence have been involved in corruption related to the extraction of natural resources.

The purpose of the law is clear: If you, as a government official or a member of your immediate family, are involved in the corrupt exploitation of natural resources, you are not welcome in the United States.

Unfortunately, despite, I believe, well-intentioned people at the State Department who support the goals of the law, it has not been applied as vigorously as it could and should be.

They do not have the resources to conduct their own investigations, so they rely on other agencies like the Departments of Justice and Homeland Security, which do not always share information and have their own standards of proof. The fact that someone like Mr. Obiang is traveling freely to and from the United States, I believe makes a mockery of the law.

This is not a partisan issue. Senators of both parties have spoken out about the corrosive effects of corruption. We saw the effects of it in our own assistance program in Iraq, where no-bid contracts and lax oversight resulted in enormous fraud and waste of taxpayer funds, and we are witnessing the effects of rampant corruption in the Afghan Government.

It is overdue for the State Department to apply section 7086 with the vigor that Congress intended. It is about promoting good governance, the rule of law, the sustainable use of natural resources, and stopping the squandering of revenues from the extraction of those resources that are urgently needed to help reduce poverty. It is time to apply the law in a manner that resonates far and wide in support of each of those goals.

ELIMINATING THE TERROR GAP

Mr. LEVIN. Mr. President, in the aftermath of the shootings at Fort Hood, TX, law enforcement officials and policymakers continue to piece together the string of events that preceded this tragedy. Although investigations of the shootings are in the early stages, a number of troubling details have already come to light. In December 2008, Major Hasan became the subject of a Joint Terrorism Task Force, JTTF, investigation after intelligence agencies intercepted his e-mail communication with a known radical cleric, Anwar al-Awlaki. After reviewing the e-mails and concluding that Major Hasan was not engaged in terrorist activities, the JTTF investigator and supervisor did not share the information regarding Major Hasan, and he was not placed on a terrorist watch list. While the lack of information sharing between the JTTF and other agencies is problematic, it is just as alarming to see that the Federal Government would have been unable to prohibit Major Hasan's firearm purchase even if he had been flagged on a terrorist watch list. Again, even if a gun background check had revealed that Major Hasan was on a terrorist watch list, nothing in current law could have prohibited the firearm transfer unless he fell into another disqualifying category. In other words, being on a terrorist watch list does not prevent someone from purchasing a gun.

This ''terror gap'' in Federal law that prevents the Federal Government from stopping the sale of firearms or explosives to a known or suspected terrorist must be eliminated. To close this loophole, I support S.1317, the Denying Firearms and Explosives to Dangerous Terrorists Act, which was introduced by Senator FRANK LAUTENBERG, D-NJ. I am a cosponsor of this common-sense legislation because it would authorize the Attorney General to deny the transfer of a firearm when an FBI background check reveals that the prospective purchaser is a known or suspected terrorist and the Attorney General has a reasonable belief that the purchaser may use the firearm in connection with terrorism. To protect the rights of American citizens, this bill would direct the Attorney General to issue guidelines describing when the authority to deny gun purchases could be used, and it would protect the private information contained in the terrorist watch lists. This legislation also includes due-process safeguards that would allow any individual whose firearms or explosives license application has been denied to bring legal action to challenge the denial.

I have long supported sensible gun safety laws and strict enforcement of those laws to help stem the tide of crimes committed with firearms. I believe Congress can and should pursue legislative solutions to prevent gun violence, and that includes passing legislation that eliminates the ''terror gap.''

BUILD AMERICA BONDS

Mr. WYDEN. Mr. President, I rise to talk about a great success story that not a lot of people have heard about. It is the story of a program that's helping create jobs and solve a lot of problems at the same time. It is the story of Build America Bonds.

These bonds came about from a piece of legislation I introduced last year as a way to shore up our Nation's crumbling infrastructure, and, at the same time, put people back to work.

In my home State of Oregon, infrastructure projects have proven to be an economic engine. People get back to work building a bridge, for example, and all the businesses near the construction site get more activity from the people who need their services. Then, once the project is finished, private investment follows that public investment. That bridge makes it easier for folks to get to work or take their kids to school, and communities grow.

Now, when I initially proposed Build America Bonds, I thought they would sell $10 billion worth, but the most recent report on the bonds has shown they are selling like hotcakes. Build America Bonds dollars are flowing into local communities, creating jobs and helping to strengthen America's infrastructure.

To date more than $50 billion worth of these innovative bonds have funded hundreds of projects in 38 States: fixing our roads and bridges, rebuilding our schools, and upgrading our utilities.

For example, in Oregon's Dayton School District they have already used Build America Bonds to employ up to 150 people building and remodeling classrooms. By using Build America Bonds, the school district saved an estimated $1.2 million in interest costs.

The city of De Pere, WI, was able to use Build America Bonds and lower its financing cost by 2.3 percent, allowing it to move forward with plans to upgrade roads, sewers, and buildings. The city's finance director, Joseph G. Zegers, told Business Week magazine that without Build America Bonds, ''some projects might not be done,'' and ''There would be less employment.''

Recently, the CBO highlighted other benefits from Build America Bonds. In an October report, the CBO found that tax-credit bonds, like Build America Bonds, can be more cost-effective than tax-exempt bonds. The report also concluded that because these bonds are more attractive to investors they are more efficient at raising capital.

Not only are these funds being raised efficiently, they are being put to work quickly. Due to Federal spending guidelines, all bond funds must be spent within 2 years of the bond being issued. This means that money is not only flowing into projects, it is being spent in the short term, funding projects and putting people back to work with little delay.

Before these bonds started being issued, the market for normal municipal bonds was frozen. It was very hard to sell municipal bonds, but that didn't mean the need for financing infrastructure wasn't still there.

Build America Bonds have changed that.

These bonds provide the option of a tax credit to investors or Federal subsidy to issuers of 35 percent of the interest earned over the life of the bond. This has proven to be a strong incentive and opened up new markets for State and local governments, giving financiers a new and profitable opportunity to invest in America.

Build America Bonds have also gained support from the private sector, including the Chamber of Commerce and the National Association of Manufacturers.

While this program has given local governments a powerful new tool in fighting the recession, time is running

out. These bonds can only be issued until the end of 2010 and I urge communities to take advantage of this landmark program. Although there is no limit on the number or amount of bonds that can be issued, the clock is ticking and the end of 2010 will be here before you know it.

I am not surprised that Build America Bonds are reinventing the municipal bond market. They are a good deal for investors and our communities. They have freed up financing for badly needed infrastructure construction, and ensured long-term economic growth.

I would also like to highlight the Recovery Zone Build America Bonds program. Recovery Zone Bonds are much like Build America Bonds but are designed to help communities most adversely affected by the recent recession.

These highly targeted bonds offer an even more generous subsidy of 45 percent of the interest to investors. Treasury allocates these bonds based on employment declines in 2008. So, the harder an area is hit, the more Recovery Zone Bonds it can issue, creating jobs where they are needed most.

In some cases, these bonds will make the difference between whether these projects come to fruition or not. In other cases, they will lower the cost of projects and allow the community to reinvest those savings in other projects.

As with Build America Bonds, Recovery Zone Bonds will only be issued until the end of 2010. That is why I am encouraging communities facing high unemployment to take advantage of the billions of dollars available in Recovery Zone Bonds.

I also encourage my colleagues in Congress to begin working now to continue the success of Build America Bonds. As Congress struggles to find funding for a new transportation bill, innovative approaches like Build America Bonds should be part of the solution.

The Build America and Recovery Zone Bond programs are working. They are providing much needed jobs to folks in our communities while strengthening essential infrastructure. They have given investors a profitable opportunity to invest in America. They are giving our children better schools, building energy efficient power grids, providing cleaner water and better roads. In short, they work.

Build America Bonds are examples of how Congress can innovate creative solutions to rebuild our country and our economy. I urge my colleagues and our constituents to use them.

ANNE SLAUGHTER ANDREW

Mr. BAYH. Mr. President, I thank you very much for allowing me to express my support for Anne Slaughter Andrew.

The strong relationship between the United States and Costa Rica is one of mutual respect, shared democratic principles, and a commitment to protecting Costa Rica's abundant natural resources. Costa Rica is a worldwide leader in green energy and sustainability—it currently generates more than 90 percent of its electricity from sustainable sources and has committed to being carbon neutral by 2021.

In recommending my fellow Hoosier, Ms. Andrew, I have the benefit of being able to speak from personal experience. When I was Governor of Indiana, I appointed her to the Indiana Natural Resources Council, an organization which engages in the conservation of Indiana's natural resources and park lands. That is one of many positions in Ms. Andrew's professional life that demonstrates her strong commitment to environmental conservation and clean energy initiatives.

Although Costa Rica covers only 0.01 percent of the Earth's landmass, it is home to approximately 5 percent of the Earth's biodiversity. The United States is committed to protecting this biodiversity through conservation efforts that contribute to the stabilization of Costa Rica's economy.

Ms. Andrew's leadership and involvement with The Nature Conservatory, TNC, in multiple capacities, including as a member of the President's Advisory Council, has spanned a decade and is a strong testament to her unwavering commitment to the preservation of Costa Rica's—and our planet's—natural resources.

Her most recent endeavor as principal of New Energy Nexus has placed her at the cutting edge of the clean energy economy. These combined experiences render her uniquely qualified to represent the United States as it looks to strengthen partnerships with Costa Rica in the field of green energy initiatives. Her service also includes founding and directing Anson Group LLC, a biotech consulting company that she co-led towards sustained growth and national recognition.

The post of Ambassador to Costa Rica carries with it the significant responsibility of managing the diplomatic personnel in country and overseeing the safety of the estimated 1 million Americans who visit Costa Rica each year and the thousands of Americans who live there full time. In her career, Ms. Andrew has demonstrated herself to be a skilled manager who is highly capable of undertaking this responsibility.

I have confidence that Ms. Andrew, if confirmed, will uphold our country's strong relations with Costa Rica.

WORLD AIDS AWARENESS DAY

Mr. BURRIS. Mr. President, today is World AIDS Awareness Day. We dedicate this day to educating Americans and citizens all over the world about the HIV/AIDS epidemic, and promoting awareness and prevention of this disease.

Despite advances in medical technology and treatment options, racial and ethnic minorities and young gay men continue to suffer in disproportionate numbers. African Americans account for 12 percent of the U.S. population, but make up almost half of the 1 million Americans living with HIV/AIDS. Black youth and young adults between the ages of 13 to 24 make up 55 percent of all reported HIV infections. Also, Black women account for almost 70 percent of all new female AIDS cases. It is also the main cause of death for both Black men and women between the ages of 25 to 44.

We continue to make considerable progress in caring for citizens with HIV/AIDS and in raising awareness, but today I call upon my colleagues to join me in demanding that we do even more. I was proud to support the expansion of the Ryan White HIV/AIDS Treatment Program in the Senate, a bill which President Obama recently signed into law. This important piece of legislation makes investments in care and treatment services, and also funds prevention and outreach programs—programs that will be improved and augmented by the sweeping health care reforms currently under consideration by the Senate. As we move forward, I will continue to work to promote awareness, education, and prevention of HIV/AIDS, and will be an ardent supporter of programs that care for those afflicted by this disease.

World AIDS Awareness Day is a chance for citizens of the United States and people all over the world to get proactively involved by getting educated, and by promoting treatment and testing of HIV/AIDS. Together, we can beat this disease.

EXECUTIVE REPORT OF COMMITTEE—TREATY

The following executive report of committee was submitted:

By Mr. KERRY, from the Committee on Foreign Relations:

[Treaty Doc. 111–4: Protocol Amending Tax Convention with France with 1 declaration and 1 condition (Ex. Rept. 111–1)]

The text of the committee-recommended resolution of advice and consent to ratification is as follows:

VIII. RESOLUTION OF ADVICE AND CONSENT TO RATIFICATION

Resolved (two-thirds of the Senators present concurring therein),

Section 1. Senate Advice and Consent subject to a declaration and a condition.

The Senate advises and consents to the ratification of the Protocol Amending the Convention between the Government of the United States of America and the Government of the French Republic for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital, signed at Paris on August 31, 1994, as Amended by the Protocol signed on December 8, 2004, signed on January 13, 2009, at Paris, together with a related Memorandum of Understanding, signed January 13, 2009 (the ''Protocol'') (Treaty Doc. 111–4), subject to the declaration of section 2 and the condition of section 3.

Section 2. Declaration. The advice and consent of the Senate under section 1 is subject to the following declaration:

The Protocol is self-executing.

Section 3. Condition. The advice and consent of the Senate under section 1 is subject to the following condition:

1. Not later than two years from the date on which this Protocol enters into force and prior to the first arbitration conducted pursuant to the binding arbitration mechanism provided for in this Protocol, the Secretary of Treasury shall transmit the text of the rules of procedure applicable to arbitration panels, including conflict of interest rules to be applied to members of the arbitration panel, to the committees on Finance and Foreign Relations of the Senate and the Joint Committee on Taxation.

2. Sixty days after a determination has been reached by an arbitration panel in the tenth arbitration proceeding conducted pursuant to this Protocol, the 2006 Protocol Amending the Convention between the United States of America and the Federal Republic of Germany for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital and to Certain Other Taxes (the ''2006 German Protocol'') (Treaty Doc. 109–20), the Convention between the Government of the United States of America and the Government of the Kingdom of Belgium for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income, and accompanying protocol (the ''Belgium Convention'') (Treaty Doc. 110–3), or the Protocol Amending the Convention between the United States of America and Canada with Respect to Taxes on Income and on Capital (the ''2007 Canada Protocol'') (Treaty Doc. 110–15), the Secretary of Treasury shall prepare and submit a detailed report to the Joint Committee on Taxation and the Committee on Finance of the Senate, subject to law relating to taxpayer confidentiality, regarding the operation and application of the arbitration mechanism contained in the aforementioned treaties. The report shall include the following information:

I. The aggregate number, for each treaty, of cases pending on the respective dates of entry into force of this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, along with the following additional information regarding these cases:

a. The number of such cases by treaty article(s) at issue;

b. The number of such cases that have been resolved by the competent authorities through a mutual agreement as of the date of the report; and

c. The number of such cases for which arbitration proceedings have commenced as of the date of the report.

II. A list of every case presented to the competent authorities after the entry into force of this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, with the following information regarding each case:

a. The commencement date of the case for purposes of determining when arbitration is available;

b. Whether the adjustment triggering the case, if any, was made by the United States or the relevant treaty partner;

c. Which treaty the case relates to;

d. The treaty article(s) at issue in the case;

e. The date the case was resolved by the competent authorities through a mutual agreement, if so resolved;

f. The date on which an arbitration proceeding commenced, if an arbitration proceeding commenced; and

g. The date on which a determination was reached by the arbitration panel, if a determination was reached, and an indication as to whether the panel found in favor of the United States or the relevant treaty partner.

III. With respect to each dispute submitted to arbitration and for which a determination was reached by the arbitration panel pursuant to this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, the following information shall be included:

a. In the case of a dispute submitted under this Protocol, an indication as to whether the presenter of the case to the competent authority of a Contracting State submitted a Position Paper for consideration by the arbitration panel;

b. An indication as to whether the determination of the arbitration panel was accepted by each concerned person;

c. The amount of income, expense, or taxation at issue in the case as determined by reference to the filings that were sufficient to set the commencement date of the case for purposes of determining when arbitration is available; and

d. The proposed resolutions (income, expense, or taxation) submitted by each competent authority to the arbitration panel.

3. The Secretary of Treasury shall, in addition, prepare and submit the detailed report described in paragraph (2) on March 1 of the year following the year in which the first report is submitted to the Joint Committee on Taxation and the Committee on Finance of the Senate, and on an annual basis thereafter for a period of five years. In each such report, disputes that were resolved, either by a mutual agreement between the relevant competent authorities or by a determination of an arbitration panel, and noted as such in prior reports may be omitted.

4. The reporting requirements referred to in paragraphs (2) and (3) supersede the reporting requirements contained in paragraphs (2) and (3) of Section 3 of the resolution of advice and consent to the 2007 Canada Protocol, approved by the Senate on September 23, 2008.

EXECUTIVE REPORT OF COMMITTEE

The following executive report of a nomination was submitted:

By Mr. LIEBERMAN for the Committee on Homeland Security and Governmental Affairs.

*Alan C. Kessler, of Pennsylvania, to be a Governor of the United States Postal Service for a term expiring December 8, 2015.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. LAUTENBERG (for himself, Mr. SCHUMER, Mr. LEVIN, Mr. REED, Mrs. FEINSTEIN, and Mr. WHITEHOUSE):

S. 2820. A bill to prevent the destruction of terrorist and criminal national instant criminal background check system records; to the Committee on the Judiciary.

By Mr. BROWN (for himself, Mr. FEINGOLD, Mr. WHITEHOUSE, Mr. DORGAN, Mr. CASEY, Mr. SANDERS, and Mr. MERKLEY):

S. 2821. A bill to require a review of existing trade agreements and renegotiation of existing trade agreements based on the review, to establish terms for future trade agreements, to express the sense of the Congress that the role of Congress in making trade policy should be strengthened, and for other purposes; to the Committee on Finance.

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2822. A bill to amend the Internal Revenue Code of 1986 to provide additional tax relief for small businesses, and for other purposes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mrs. BOXER:

S. Res. 365. A resolution recognizing the 50th anniversary of the signing of the Antarctic Treaty; considered and agreed to.

ADDITIONAL COSPONSORS

S. 229

At the request of Mrs. BOXER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 229, a bill to empower women in Afghanistan, and for other purposes.

S. 584

At the request of Mr. HARKIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 584, a bill to ensure that all users of the transportation system, including pedestrians, bicyclists, transit users, children, older individuals, and individuals with disabilities, are able to travel safely and conveniently on and across federally funded streets and highways.

S. 970

At the request of Ms. LANDRIEU, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 970, a bill to promote and enhance the operation of local building code enforcement administration across the country by establishing a competitive Federal matching grant program.

S. 1067

At the request of Mr. FEINGOLD, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1090

At the request of Mr. WYDEN, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 1090, a bill to amend the Internal Revenue Code of 1986 to provide tax credit parity for electricity produced from renewable resources.

S. 1156

At the request of Mr. HARKIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1156, a bill to amend the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users to reauthorize and improve the safe routes to school program.

S. 1317

At the request of Mr. LAUTENBERG, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1317, a bill to increase public safety by permitting the Attorney General to deny the transfer of firearms or the issuance of firearms and explosives licenses to known or suspected dangerous terrorists.

S. 1583

At the request of Mr. ROCKEFELLER, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1583, a bill to amend the Internal Revenue Code of 1986 to extend the new markets tax credit through 2014, and for other purposes.

S. 1606

At the request of Mr. WHITEHOUSE, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1606, a bill to require foreign manufacturers of products imported into the United States to establish registered agents in the United States who are authorized to accept service of process against such manufacturers, and for other purposes.

S. 1660

At the request of Ms. KLOBUCHAR, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1660, a bill to amend the Toxic Substances Control Act to reduce the emissions of formaldehyde from composite wood products, and for other purposes.

S. 1672

At the request of Mr. REED, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1672, a bill to reauthorize the National Oilheat Research Alliance Act of 2000.

S. 1743

At the request of Mrs. LINCOLN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 1743, a bill to amend the Internal Revenue Code of 1986 to expand the rehabilitation credit, and for other purposes.

S. 1756

At the request of Mr. HARKIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 1756, a bill to amend the Age Discrimination in Employment Act of 1967 to clarify the appropriate standard of proof.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1966

At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1966, a bill to provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes.

S. 2607

At the request of Mr. REID, the name of the Senator from Idaho (Mr. RISCH) was added as a cosponsor of S. 2607, a bill to amend the Department of the Interior, Environment, and Related Agencies Appropriations Act, 2010 to repeal a provision of that Act relating to geothermal energy receipts.

S. 2730

At the request of Mr. BROWN, the names of the Senator from Rhode Island (Mr. REED), the Senator from Minnesota (Ms. KLOBUCHAR), the Senator from Connecticut (Mr. DODD) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2794

At the request of Mr. SCHUMER, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 2816

At the request of Mr. BUNNING, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 2816, a bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs and to allow the adoption credit to be claimed in the year expenses are incurred, regardless of when the adoption becomes final.

S. RES. 356

At the request of Mr. CARDIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. Res. 356, a resolution calling upon the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay.

AMENDMENT NO. 2791

At the request of Ms. MIKULSKI, the names of the Senator from Washington (Mrs. MURRAY), the Senator from Maryland (Mr. CARDIN), the Senator from Maine (Ms. SNOWE), the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. DODD), the Senator from Michigan (Ms. STABENOW), the Senator from New York (Mr. SCHUMER), the Senator from Ohio (Mr. BROWN), the Senator from Vermont (Mr. LEAHY) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of amendment No. 2791 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2822. A bill to amend the Internal Revenue Code of 1986 to provide additional tax relief for small businesses, and for other purposes; to the Committee on Finance.

Ms. SNOWE. Mr. President, I rise today, along with Senator LANDRIEU, to introduce legislation to make permanent a critical tax incentive currently being utilized by our Nation's small businesses, which will enable them to continue to make vital investments in new plant and equipment. The American Recovery and Reinvestment Act, ARRA, included a crucial provision that extended enhanced small business expensing at $250,000 through 2009. My legislation would make the incentive permanent and, in turn, provide valuable assistance to America's 26 million small firms that represent over 99.7 percent of all employers.

I have long championed enhanced section 179 expensing, which allows small businesses to elect to deduct the cost of qualifying property in the year it was purchased, rather than to recover such costs through depreciation deductions over a number of years. In 2007, I introduced legislation to make permanent section 179 expensing, and in 2008, Congress, as part of the Economic Stimulus Act of 2008, allowed small businesses in Maine and across the Nation to expense up to $250,000 of their investments, including the purchase of essential new equipment.

Congress further reinforced the necessity of this legislation by extending the provision through 2009 in the ARRA. Unfortunately, the ARRA extension was written to last just 1 year, as a result, in 2010, absent additional action, small firms will be able to expense just $134,000 of new capital investment. The provision will be further reduced to $25,000 in 2011, and instead of being able to write off more of their equipment purchases immediately, firms will have to recover their costs over 5, 7, or more years.

Small businesses continue to struggle as a result of the current recession, and many are having trouble finding capital to make job-creating new investments. We simply cannot allow this pattern to continue, Accordingly, my bill would allow small businesses to continue expensing up to $250,000 of new investment permanently. By permitting small businesses to write off more of their equipment purchases today, they will retain substantial savings instead of waiting 5, 7, or more years to recover their costs through depreciation. Additionally, this will save them the vital time that is required to

comply with complex and confusing depreciation rules. Accordingly, this provision encourages stable investment in new equipment that will contribute to continued productivity and growth in the business community.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There begin no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2822

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

This Act may be cited as the ''Small Business Expensing Permanency Act''.

SEC. 2. PERMANENT INCREASE IN LIMITATIONS ON EXPENSING OF CERTAIN DEPRECIABLE BUSINESS ASSETS.

(a) IN GENERAL.—Subsection (b) of section 179 of the Internal Revenue Code of 1986 (relating to limitations) is amended—

(1) by striking ''$25,000'' and all that follows in paragraph (1) and inserting ''$250,000.'',

(2) by striking''$200,000'' and all that follows in paragraph (2) and inserting ''$800,000'',

(3) by striking ''after 2007 and before 2011, the $120,000 and $500,000'' in paragraph (5)(A) and inserting ''after 2009, the $250,000 and the $800,000'',

(4) by striking ''2006'' in paragraph (5)(A)(ii) and inserting ''2008'', and

(5) by striking paragraph (7).

(b) PERMANENT EXPENSING OF COMPUTER SOFTWARE.—Section 179(d)(1)(A)(ii) of the Internal Revenue Code of 1986 (defining section 179 property) is amended by striking ''and before 2011''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 365—RECOGNIZING THE 50TH ANNIVERSARY OF THE SIGNING OF THE ANTARCTIC TREATY

Mr. DURBIN submitted the following resolution; which was considered and agreed to:

S. RES. 365

Whereas the Antarctic Treaty was signed by 12 nations in Washington, DC, on December 1, 1959, ''with the interests of science and the progress of all mankind'';

Whereas the Antarctic Treaty was established to continue and develop international ''cooperation on the basis of freedom of scientific investigation in Antarctica as applied during the International Geophysical Year'';

Whereas the Antarctic Treaty came into force on June 23, 1961, after its unanimous ratification by the seven countries (Argentina, Australia, Chile, France, New Zealand, Norway, and the United Kingdom) with territorial claims in the region and five other countries (Belgium, Japan, South Africa, the Soviet Union, and the United States), which had collaborated in Antarctic research activities during the International Geophysical Year from July 1, 1957, through December 31, 1958;

Whereas the Antarctic Treaty now has 47 nations as signatories that together represent nearly 90 percent of humanity;

Whereas Article IV of the Antarctic Treaty states that ''no acts or activities taking place while the present Treaty is in force shall constitute a basis for asserting, supporting or denying a claim to territorial sovereignty in Antarctica'';

Whereas the 14 articles of the Antarctic Treaty have provided a lasting foundation for maintaining the region south of 60 degrees south latitude, nearly 10 percent of the Earth's surface, ''for peaceful purposes only'';

Whereas the Antarctic Treaty prohibits ''any measure of a military nature'';

Whereas the Antarctic Treaty has promoted international nuclear cooperation by prohibiting ''any nuclear explosions in Antarctica and the disposal there of radioactive waste material'';

Whereas the Antarctic Treaty provides a framework for the signatories to continue to meet ''for the purpose of exchanging information, consulting together on matters of common interest pertaining to Antarctica, and formulating and considering, and recommending to their Governments, measures in furtherance of the principles and objectives of the Treaty'';

Whereas common interests among the Antarctic Treaty nations facilitated the development and ratification of the Convention on the Conservation of Antarctic Marine Living Resources;

Whereas the international cooperation represented by the Antarctic Treaty offers humankind a precedent for the peaceful governance of international spaces;

Whereas in celebration of the 50th anniversary of the International Geophysical Year, the Antarctic Treaty Parties in their Edinburgh Declaration recognized the current International Polar Year for its contributions to science worldwide and to international cooperation; and

Whereas the International Polar Year program has endorsed the Antarctic Treaty Summit that will convene in Washington, DC, at the Smithsonian Institution on the 50th anniversary of the Antarctic Treaty: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes that the Antarctic Treaty has greatly contributed to science and science cooperation worldwide and successfully ensured the ''use of Antarctica for peaceful purposes only and the continuance of international harmony'' for the past half century; and

(2) encourages international and interdisciplinary collaboration in the Antarctic Treaty Summit to identify lessons from 50 years of international cooperation under the Antarctic Treaty that have legacy value for humankind.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2792. Mr. KAUFMAN (for himself, Mr. LEAHY, Mr. SPECTER, Mr. KOHL, Mr. SCHUMER, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2793. Mr. DORGAN (for himself, Ms. SNOWE, Mr. GRASSLEY, Mr. MCCAIN, Ms. STABENOW, Ms. KLOBUCHAR, Mr. BROWN, Mrs. SHAHEEN, Mr. VITTER, Mr. KOHL, Mr. LEAHY, Mr. FEINGOLD, and Mr. NELSON, of Florida) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2794. Mr. LEAHY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2795. Mr. LEAHY (for himself, Mr. REID, Mr. KERRY, Mr. ROCKEFELLER, Mr. LIEBERMAN, Mrs. FEINSTEIN, Mr. FEINGOLD, Mr. WYDEN, Mr. SCHUMER, Ms. CANTWELL, Mr. LAUTENBERG, Mrs. MCCASKILL, Mr. WHITEHOUSE, Mr. BURRIS, Mr. KAUFMAN, Mr. BENNET, and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2796. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

SA 2797. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, supra.

TEXT OF AMENDMENTS

SA 2792. Mr. KAUFMAN (for himself, Mr. LEAHY, Mr. SPECTER, Mr. KOHL, Mr. SCHUMER, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1738, between lines 3 and 4, insert the following:

(3) OTHER ENHANCEMENTS RELATING TO HEALTH CARE FRAUD.—

(A) FRAUD SENTENCING GUIDELINES.—

(i) DEFINITION.—In this subparagraph, the term ''Federal health care offense'' has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(ii) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subparagraph, the United States Sentencing Commission shall—

(I) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(II) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(III) amend the Federal Sentencing Guidelines to provide—

(aa) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000;

(bb) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000;

(cc) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $20,000,000; and

(dd) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(iii) REQUIREMENTS.—In carrying this subparagraph, the United States Sentencing Commission shall—

(I) ensure that the Federal Sentencing Guidelines and policy statements—

(aa) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(bb) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(II) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in clause (ii);

(III) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(IV) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(V) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(VI) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(B) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(i) by inserting ''(a)'' before ''Whoever knowingly''; and

(ii) by adding at the end the following:

''(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(C) HEALTH CARE FRAUD OFFENSE.—Section 24(a) of title 18, United States Code, is amended—

(i) in paragraph (1), by striking the semicolon and inserting ''or section 1128B of the Social Security Act (42 U.S.C. 1320a-7b); or''; and

(ii) in paragraph (2)—

(I) by inserting ''1349,'' after ''1343,''; and

(II) by inserting ''section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131),'' after ''title,''.

(D) SUBPOENA AUTHORITY RELATING TO HEALTH CARE.—

(i) SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(I) in paragraph (1), by striking ''to the grand jury''; and

(II) in paragraph (2)—

(aa) in subparagraph (A), by striking ''grand jury subpoena'' and inserting ''subpoena for records''; and

(bb) in the matter following subparagraph (B), by striking ''to the grand jury''.

(ii) SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

''SEC. 3A. SUBPOENA AUTHORITY.

''(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

''(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

''(1) ISSUANCE.—Subpoenas issued under this section—

''(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

''(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

''(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt that court.

''(c) PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

''(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

''(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

''(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.''.

SA 2793. Mr. DORGAN (for himself, Ms. SNOWE, Mr. GRASSLEY, Mr. MCCAIN, Ms. STABENOW, Ms. KLOBUCHAR, Mr. BROWN, Mrs. SHAHEEN, Mr. VITTER, Mr. KOHL, Mr. LEAHY, Mr. FEINGOLD, and Mr. NELSON of Florida) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 10001. SHORT TITLE.

This title may be cited as the ''Pharmaceutical Market Access and Drug Safety Act of 2009''.

SEC. 10002. FINDINGS.

Congress finds that—

(1) Americans unjustly pay up to 5 times more to fill their prescriptions than consumers in other countries;

(2) the United States is the largest market for pharmaceuticals in the world, yet American consumers pay the highest prices for brand pharmaceuticals in the world;

(3) a prescription drug is neither safe nor effective to an individual who cannot afford it;

(4) allowing and structuring the importation of prescription drugs to ensure access to safe and affordable drugs approved by the Food and Drug Administration will provide a level of safety to American consumers that they do not currently enjoy;

(5) American spend more than $200,000,000,000 on prescription drugs every year;

(6) the Congressional Budget Office has found that the cost of prescription drugs are between 35 to 55 percent less in other highly-developed countries than in the United States; and

(7) promoting competitive market pricing would both contribute to health care savings and allow greater access to therapy, improving health and saving lives.

SEC. 10003. REPEAL OF CERTAIN SECTION REGARDING IMPORTATION OF PRESCRIPTION DRUGS.

Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804.

SEC. 10004. IMPORTATION OF PRESCRIPTION DRUGS; WAIVER OF CERTAIN IMPORT RESTRICTIONS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.), as amended by section 10003, is further amended by inserting after section 803 the following:

''SEC. 804. COMMERCIAL AND PERSONAL IMPORTATION OF PRESCRIPTION DRUGS.

''(a) IMPORTATION OF PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—In the case of qualifying drugs imported or offered for import into the United States from registered exporters or by registered importers—

''(A) the limitation on importation that is established in section 801(d)(1) is waived; and

''(B) the standards referred to in section 801(a) regarding admission of the drugs are subject to subsection (g) of this section (including with respect to qualifying drugs to which section 801(d)(1) does not apply).

''(2) IMPORTERS.—A qualifying drug may not be imported under paragraph (1) unless—

''(A) the drug is imported by a pharmacy, group of pharmacies, or a wholesaler that is a registered importer; or

''(B) the drug is imported by an individual for personal use or for the use of a family member of the individual (not for resale) from a registered exporter.

''(3) RULE OF CONSTRUCTION.—This section shall apply only with respect to a drug that is imported or offered for import into the United States—

''(A) by a registered importer; or

''(B) from a registered exporter to an individual.

''(4) DEFINITIONS.—

''(A) REGISTERED EXPORTER; REGISTERED IMPORTER.—For purposes of this section:

''(i) The term 'registered exporter' means an exporter for which a registration under

subsection (b) has been approved and is in effect.

''(ii) The term 'registered importer' means a pharmacy, group of pharmacies, or a wholesaler for which a registration under subsection (b) has been approved and is in effect.

''(iii) The term 'registration condition' means a condition that must exist for a registration under subsection (b) to be approved.

''(B) QUALIFYING DRUG.—For purposes of this section, the term 'qualifying drug' means a drug for which there is a corresponding U.S. label drug.

''(C) U.S. LABEL DRUG.—For purposes of this section, the term 'U.S. label drug' means a prescription drug that—

''(i) with respect to a qualifying drug, has the same active ingredient or ingredients, route of administration, dosage form, and strength as the qualifying drug;

''(ii) with respect to the qualifying drug, is manufactured by or for the person that manufactures the qualifying drug;

''(iii) is approved under section 505(c); and

''(iv) is not—

''(I) a controlled substance, as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802);

''(II) a biological product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262), including—

''(aa) a therapeutic DNA plasmid product;

''(bb) a therapeutic synthetic peptide product;

''(cc) a monoclonal antibody product for in vivo use; and

''(dd) a therapeutic recombinant DNA-derived product;

''(III) an infused drug, including a peritoneal dialysis solution;

''(IV) an injected drug;

''(V) a drug that is inhaled during surgery;

''(VI) a drug that is the listed drug referred to in 2 or more abbreviated new drug applications under which the drug is commercially marketed; or

''(VII) a sterile opthlamic drug intended for topical use on or in the eye.

''(D) OTHER DEFINITIONS.—For purposes of this section:

''(i)(I) The term 'exporter' means a person that is in the business of exporting a drug to individuals in the United States from Canada or from a permitted country designated by the Secretary under subclause (II), or that, pursuant to submitting a registration under subsection (b), seeks to be in such business.

''(II) The Secretary shall designate a permitted country under subparagraph (E) (other than Canada) as a country from which an exporter may export a drug to individuals in the United States if the Secretary determines that—

''(aa) the country has statutory or regulatory standards that are equivalent to the standards in the United States and Canada with respect to—

''(AA) the training of pharmacists;

''(BB) the practice of pharmacy; and

''(CC) the protection of the privacy of personal medical information; and

''(bb) the importation of drugs to individuals in the United States from the country will not adversely affect public health.

''(ii) The term 'importer' means a pharmacy, a group of pharmacies, or a wholesaler that is in the business of importing a drug into the United States or that, pursuant to submitting a registration under subsection (b), seeks to be in such business.

''(iii) The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

''(iv) The term 'pharmacy' means a person that—

''(I) is licensed by a State to engage in the business of selling prescription drugs at retail; and

''(II) employs 1 or more pharmacists.

''(v) The term 'prescription drug' means a drug that is described in section 503(b)(1).

''(vi) The term 'wholesaler'—

''(I) means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A); and

''(II) does not include a person authorized to import drugs under section 801(d)(1).

''(E) PERMITTED COUNTRY.—The term 'permitted country' means—

''(i) Australia;

''(ii) Canada;

''(iii) a member country of the European Union, but does not include a member country with respect to which—

''(I) the country's Annex to the Treaty of Accession to the European Union 2003 includes a transitional measure for the regulation of human pharmaceutical products that has not expired; or

''(II) the Secretary determines that the requirements described in subclauses (I) and (II) of clause (vii) will not be met by the date on which such transitional measure for the regulation of human pharmaceutical products expires;

''(iv) Japan;

''(v) New Zealand;

''(vi) Switzerland; and

''(vii) a country in which the Secretary determines the following requirements are met:

''(I) The country has statutory or regulatory requirements—

''(aa) that require the review of drugs for safety and effectiveness by an entity of the government of the country;

''(bb) that authorize the approval of only those drugs that have been determined to be safe and effective by experts employed by or acting on behalf of such entity and qualified by scientific training and experience to evaluate the safety and effectiveness of drugs on the basis of adequate and well-controlled investigations, including clinical investigations, conducted by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs;

''(cc) that require the methods used in, and the facilities and controls used for the manufacture, processing, and packing of drugs in the country to be adequate to preserve their identity, quality, purity, and strength;

''(dd) for the reporting of adverse reactions to drugs and procedures to withdraw approval and remove drugs found not to be safe or effective; and

''(ee) that require the labeling and promotion of drugs to be in accordance with the approval of the drug.

''(II) The valid marketing authorization system in the country is equivalent to the systems in the countries described in clauses (i) through (vi).

''(III) The importation of drugs to the United States from the country will not adversely affect public health.

''(b) REGISTRATION OF IMPORTERS AND EXPORTERS.—

''(1) REGISTRATION OF IMPORTERS AND EXPORTERS.—A registration condition is that the importer or exporter involved (referred to in this subsection as a 'registrant') submits to the Secretary a registration containing the following:

''(A)(i) In the case of an exporter, the name of the exporter and an identification of all places of business of the exporter that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the exporter.

''(ii) In the case of an importer, the name of the importer and an identification of the places of business of the importer at which the importer initially receives a qualifying drug after importation (which shall not exceed 3 places of business except by permission of the Secretary).

''(B) Such information as the Secretary determines to be necessary to demonstrate that the registrant is in compliance with registration conditions under—

''(i) in the case of an importer, subsections (c), (d), (e), (g), and (j) (relating to the sources of imported qualifying drugs; the inspection of facilities of the importer; the payment of fees; compliance with the standards referred to in section 801(a); and maintenance of records and samples); or

''(ii) in the case of an exporter, subsections (c), (d), (f), (g), (h), (i), and (j) (relating to the sources of exported qualifying drugs; the inspection of facilities of the exporter and the marking of compliant shipments; the payment of fees; and compliance with the standards referred to in section 801(a); being licensed as a pharmacist; conditions for individual importation; and maintenance of records and samples).

''(C) An agreement by the registrant that the registrant will not under subsection (a) import or export any drug that is not a qualifying drug.

''(D) An agreement by the registrant to—

''(i) notify the Secretary of a recall or withdrawal of a qualifying drug distributed in a permitted country that the registrant has exported or imported, or intends to export or import, to the United States under subsection (a);

''(ii) provide for the return to the registrant of such drug; and

''(iii) cease, or not begin, the exportation or importation of such drug unless the Secretary has notified the registrant that exportation or importation of such drug may proceed.

''(E) An agreement by the registrant to ensure and monitor compliance with each registration condition, to promptly correct any noncompliance with such a condition, and to promptly report to the Secretary any such noncompliance.

''(F) A plan describing the manner in which the registrant will comply with the agreement under subparagraph (E).

''(G) An agreement by the registrant to enforce a contract under subsection (c)(3)(B) against a party in the chain of custody of a qualifying drug with respect to the authority of the Secretary under clauses (ii) and (iii) of that subsection.

''(H) An agreement by the registrant to notify the Secretary not more than 30 days before the registrant intends to make the change, of—

''(i) any change that the registrant intends to make regarding information provided under subparagraph (A) or (B); and

''(ii) any change that the registrant intends to make in the compliance plan under subparagraph (F).

''(I) In the case of an exporter:

''(i) An agreement by the exporter that a qualifying drug will not under subsection (a) be exported to any individual not authorized pursuant to subsection (a)(2)(B) to be an importer of such drug.

''(ii) An agreement to post a bond, payable to the Treasury of the United States that is equal in value to the lesser of—

''(I) the value of drugs exported by the exporter to the United States in a typical 4-week period over the course of a year under this section; or

''(II) $1,000,000.

''(iii) An agreement by the exporter to comply with applicable provisions of Canadian law, or the law of the permitted country

designated under subsection (a)(4)(D)(i)(II) in which the exporter is located, that protect the privacy of personal information with respect to each individual importing a prescription drug from the exporter under subsection (a)(2)(B).

''(iv) An agreement by the exporter to report to the Secretary—

''(I) not later than August 1 of each fiscal year, the total price and the total volume of drugs exported to the United States by the exporter during the 6-month period from January 1 through June 30 of that year; and

''(II) not later than January 1 of each fiscal year, the total price and the total volume of drugs exported to the United States by the exporter during the previous fiscal year.

''(J) In the case of an importer, an agreement by the importer to report to the Secretary—

''(i) not later than August 1 of each fiscal year, the total price and the total volume of drugs imported to the United States by the importer during the 6-month period from January 1 through June 30 of that fiscal year; and

''(ii) not later than January 1 of each fiscal year, the total price and the total volume of drugs imported to the United States by the importer during the previous fiscal year.

''(K) Such other provisions as the Secretary may require by regulation to protect the public health while permitting—

''(i) the importation by pharmacies, groups of pharmacies, and wholesalers as registered importers of qualifying drugs under subsection (a); and

''(ii) importation by individuals of qualifying drugs under subsection (a).

''(2) APPROVAL OR DISAPPROVAL OF REGISTRATION.—

''(A) IN GENERAL.—Not later than 90 days after the date on which a registrant submits to the Secretary a registration under paragraph (1), the Secretary shall notify the registrant whether the registration is approved or is disapproved. The Secretary shall disapprove a registration if there is reason to believe that the registrant is not in compliance with one or more registration conditions, and shall notify the registrant of such reason. In the case of a disapproved registration, the Secretary shall subsequently notify the registrant that the registration is approved if the Secretary determines that the registrant is in compliance with such conditions.

''(B) CHANGES IN REGISTRATION INFORMATION.—Not later than 30 days after receiving a notice under paragraph (1)(H) from a registrant, the Secretary shall determine whether the change involved affects the approval of the registration of the registrant under paragraph (1), and shall inform the registrant of the determination.

''(3) PUBLICATION OF CONTACT INFORMATION FOR REGISTERED EXPORTERS.—Through the Internet website of the Food and Drug Administration and a toll-free telephone number, the Secretary shall make readily available to the public a list of registered exporters, including contact information for the exporters. Promptly after the approval of a registration submitted under paragraph (1), the Secretary shall update the Internet website and the information provided through the toll-free telephone number accordingly.

''(4) SUSPENSION AND TERMINATION.—

''(A) SUSPENSION.—With respect to the effectiveness of a registration submitted under paragraph (1):

''(i) Subject to clause (ii), the Secretary may suspend the registration if the Secretary determines, after notice and opportunity for a hearing, that the registrant has failed to maintain substantial compliance with a registration condition.

''(ii) If the Secretary determines that, under color of the registration, the exporter has exported a drug or the importer has imported a drug that is not a qualifying drug, or a drug that does not comply with subsection (g)(2)(A) or (g)(4), or has exported a qualifying drug to an individual in violation of subsection (i), the Secretary shall immediately suspend the registration. A suspension under the preceding sentence is not subject to the provision by the Secretary of prior notice, and the Secretary shall provide to the registrant an opportunity for a hearing not later than 10 days after the date on which the registration is suspended.

''(iii) The Secretary may reinstate the registration, whether suspended under clause (i) or (ii), if the Secretary determines that the registrant has demonstrated that further violations of registration conditions will not occur.

''(B) TERMINATION.—The Secretary, after notice and opportunity for a hearing, may terminate the registration under paragraph (1) of a registrant if the Secretary determines that the registrant has engaged in a pattern or practice of violating 1 or more registration conditions, or if on 1 or more occasions the Secretary has under subparagraph (A)(ii) suspended the registration of the registrant. The Secretary may make the termination permanent, or for a fixed period of not less than 1 year. During the period in which the registration is terminated, any registration submitted under paragraph (1) by the registrant, or a person that is a partner in the export or import enterprise, or a principal officer in such enterprise, and any registration prepared with the assistance of the registrant or such a person, has no legal effect under this section.

''(5) DEFAULT OF BOND.—A bond required to be posted by an exporter under paragraph (1)(I)(ii) shall be defaulted and paid to the Treasury of the United States if, after opportunity for an informal hearing, the Secretary determines that the exporter has—

''(A) exported a drug to the United States that is not a qualifying drug or that is not in compliance with subsection (g)(2)(A), (g)(4), or (i); or

''(B) failed to permit the Secretary to conduct an inspection described under subsection (d).

''(c) SOURCES OF QUALIFYING DRUGS.—A registration condition is that the exporter or importer involved agrees that a qualifying drug will under subsection (a) be exported or imported into the United States only if there is compliance with the following:

''(1) The drug was manufactured in an establishment—

''(A) required to register under subsection (h) or (i) of section 510; and

''(B)(i) inspected by the Secretary; or

''(ii) for which the Secretary has elected to rely on a satisfactory report of a good manufacturing practice inspection of the establishment from a permitted country whose regulatory system the Secretary recognizes as equivalent under a mutual recognition agreement, as provided for under section 510(i)(3), section 803, or part 26 of title 21, Code of Federal Regulations (or any corresponding successor rule or regulation).

''(2) The establishment is located in any country, and the establishment manufactured the drug for distribution in the United States or for distribution in 1 or more of the permitted countries (without regard to whether in addition the drug is manufactured for distribution in a foreign country that is not a permitted country).

''(3) The exporter or importer obtained the drug—

''(A) directly from the establishment; or

''(B) directly from an entity that, by contract with the exporter or importer—

''(i) provides to the exporter or importer a statement (in such form and containing such information as the Secretary may require) that, for the chain of custody from the establishment, identifies each prior sale, purchase, or trade of the drug (including the date of the transaction and the names and addresses of all parties to the transaction);

''(ii) agrees to permit the Secretary to inspect such statements and related records to determine their accuracy;

''(iii) agrees, with respect to the qualifying drugs involved, to permit the Secretary to inspect warehouses and other facilities, including records, of the entity for purposes of determining whether the facilities are in compliance with any standards under this Act that are applicable to facilities of that type in the United States; and

''(iv) has ensured, through such contractual relationships as may be necessary, that the Secretary has the same authority regarding other parties in the chain of custody from the establishment that the Secretary has under clauses (ii) and (iii) regarding such entity.

''(4)(A) The foreign country from which the importer will import the drug is a permitted country; or

''(B) The foreign country from which the exporter will export the drug is the permitted country in which the exporter is located.

''(5) During any period in which the drug was not in the control of the manufacturer of the drug, the drug did not enter any country that is not a permitted country.

''(6) The exporter or importer retains a sample of each lot of the drug for testing by the Secretary.

''(d) INSPECTION OF FACILITIES; MARKING OF SHIPMENTS.—

''(1) INSPECTION OF FACILITIES.—A registration condition is that, for the purpose of assisting the Secretary in determining whether the exporter involved is in compliance with all other registration conditions—

''(A) the exporter agrees to permit the Secretary—

''(i) to conduct onsite inspections, including monitoring on a day-to-day basis, of places of business of the exporter that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the exporter;

''(ii) to have access, including on a day-to-day basis, to—

''(I) records of the exporter that relate to the export of such drugs, including financial records; and

''(II) samples of such drugs;

''(iii) to carry out the duties described in paragraph (3); and

''(iv) to carry out any other functions determined by the Secretary to be necessary regarding the compliance of the exporter; and

''(B) the Secretary has assigned 1 or more employees of the Secretary to carry out the functions described in this subsection for the Secretary randomly, but not less than 12 times annually, on the premises of places of businesses referred to in subparagraph (A)(i), and such an assignment remains in effect on a continuous basis.

''(2) MARKING OF COMPLIANT SHIPMENTS.—A registration condition is that the exporter involved agrees to affix to each shipping container of qualifying drugs exported under subsection (a) such markings as the Secretary determines to be necessary to identify the shipment as being in compliance with all registration conditions. Markings under the preceding sentence shall—

''(A) be designed to prevent affixation of the markings to any shipping container that is not authorized to bear the markings; and

''(B) include anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies.

''(3) CERTAIN DUTIES RELATING TO EXPORTERS.—Duties of the Secretary with respect to an exporter include the following:

''(A) Inspecting, randomly, but not less than 12 times annually, the places of business of the exporter at which qualifying drugs are stored and from which qualifying drugs are shipped.

''(B) During the inspections under subparagraph (A), verifying the chain of custody of a statistically significant sample of qualifying drugs from the establishment in which the drug was manufactured to the exporter, which shall be accomplished or supplemented by the use of anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies, except that a drug that lacks such technologies from the point of manufacture shall not for that reason be excluded from importation by an exporter.

''(C) Randomly reviewing records of exports to individuals for the purpose of determining whether the drugs are being imported by the individuals in accordance with the conditions under subsection (i). Such reviews shall be conducted in a manner that will result in a statistically significant determination of compliance with all such conditions.

''(D) Monitoring the affixing of markings under paragraph (2).

''(E) Inspecting as the Secretary determines is necessary the warehouses and other facilities, including records, of other parties in the chain of custody of qualifying drugs.

''(F) Determining whether the exporter is in compliance with all other registration conditions.

''(4) PRIOR NOTICE OF SHIPMENTS.—A registration condition is that, not less than 8 hours and not more than 5 days in advance of the time of the importation of a shipment of qualifying drugs, the importer involved agrees to submit to the Secretary a notice with respect to the shipment of drugs to be imported or offered for import into the United States under subsection (a). A notice under the preceding sentence shall include—

''(A) the name and complete contact information of the person submitting the notice;

''(B) the name and complete contact information of the importer involved;

''(C) the identity of the drug, including the established name of the drug, the quantity of the drug, and the lot number assigned by the manufacturer;

''(D) the identity of the manufacturer of the drug, including the identity of the establishment at which the drug was manufactured;

''(E) the country from which the drug is shipped;

''(F) the name and complete contact information for the shipper of the drug;

''(G) anticipated arrival information, including the port of arrival and crossing location within that port, and the date and time;

''(H) a summary of the chain of custody of the drug from the establishment in which the drug was manufactured to the importer;

''(I) a declaration as to whether the Secretary has ordered that importation of the drug from the permitted country cease under subsection (g)(2)(C) or (D); and

''(J) such other information as the Secretary may require by regulation.

''(5) MARKING OF COMPLIANT SHIPMENTS.—A registration condition is that the importer involved agrees, before wholesale distribution (as defined in section 503(e)) of a qualifying drug that has been imported under subsection (a), to affix to each container of such drug such markings or other technology as the Secretary determines necessary to identify the shipment as being in compliance with all registration conditions, except that the markings or other technology shall not be required on a drug that bears comparable, compatible markings or technology from the manufacturer of the drug. Markings or other technology under the preceding sentence shall—

''(A) be designed to prevent affixation of the markings or other technology to any container that is not authorized to bear the markings; and

''(B) shall include anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of such technologies.

''(6) CERTAIN DUTIES RELATING TO IMPORTERS.—Duties of the Secretary with respect to an importer include the following:

''(A) Inspecting, randomly, but not less than 12 times annually, the places of business of the importer at which a qualifying drug is initially received after importation.

''(B) During the inspections under subparagraph (A), verifying the chain of custody of a statistically significant sample of qualifying drugs from the establishment in which the drug was manufactured to the importer, which shall be accomplished or supplemented by the use of anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies, except that a drug that lacks such technologies from the point of manufacture shall not for that reason be excluded from importation by an importer.

''(C) Reviewing notices under paragraph (4).

''(D) Inspecting as the Secretary determines is necessary the warehouses and other facilities, including records of other parties in the chain of custody of qualifying drugs.

''(E) Determining whether the importer is in compliance with all other registration conditions.

''(e) IMPORTER FEES.—

''(1) REGISTRATION FEE.—A registration condition is that the importer involved pays to the Secretary a fee of $10,000 due on the date on which the importer first submits the registration to the Secretary under subsection (b).

''(2) INSPECTION FEE.—A registration condition is that the importer involved pays a fee to the Secretary in accordance with this subsection. Such fee shall be paid not later than October 1 and April 1 of each fiscal year in the amount provided for under paragraph (3).

''(3) AMOUNT OF INSPECTION FEE.—

''(A) AGGREGATE TOTAL OF FEES.—Not later than 30 days before the start of each fiscal year, the Secretary, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, shall establish an aggregate total of fees to be collected under paragraph (2) for importers for that fiscal year that is sufficient, and not more than necessary, to pay the costs for that fiscal year of administering this section with respect to registered importers, including the costs associated with—

''(i) inspecting the facilities of registered importers, and of other entities in the chain of custody of a qualifying drug as necessary, under subsection (d)(6);

''(ii) developing, implementing, and operating under such subsection an electronic system for submission and review of the notices required under subsection (d)(4) with respect to shipments of qualifying drugs under subsection (a) to assess compliance with all registration conditions when such shipments are offered for import into the United States; and

''(iii) inspecting such shipments as necessary, when offered for import into the United States to determine if such a shipment should be refused admission under subsection (g)(5).

''(B) LIMITATION.—Subject to subparagraph (C), the aggregate total of fees collected under paragraph (2) for a fiscal year shall not exceed 2.5 percent of the total price of qualifying drugs imported during that fiscal year into the United States by registered importers under subsection (a).

''(C) TOTAL PRICE OF DRUGS.—

''(i) ESTIMATE.—For the purposes of complying with the limitation described in subparagraph (B) when establishing under subparagraph (A) the aggregate total of fees to be collected under paragraph (2) for a fiscal year, the Secretary shall estimate the total price of qualifying drugs imported into the United States by registered importers during that fiscal year by adding the total price of qualifying drugs imported by each registered importer during the 6-month period from January 1 through June 30 of the previous fiscal year, as reported to the Secretary by each registered importer under subsection (b)(1)(J).

''(ii) CALCULATION.—Not later than March 1 of the fiscal year that follows the fiscal year for which the estimate under clause (i) is made, the Secretary shall calculate the total price of qualifying drugs imported into the United States by registered importers during that fiscal year by adding the total price of qualifying drugs imported by each registered importer during that fiscal year, as reported to the Secretary by each registered importer under subsection (b)(1)(J).

''(iii) ADJUSTMENT.—If the total price of qualifying drugs imported into the United States by registered importers during a fiscal year as calculated under clause (ii) is less than the aggregate total of fees collected under paragraph (2) for that fiscal year, the Secretary shall provide for a pro-rata reduction in the fee due from each registered importer on April 1 of the subsequent fiscal year so that the limitation described in subparagraph (B) is observed.

''(D) INDIVIDUAL IMPORTER FEE.—Subject to the limitation described in subparagraph (B), the fee under paragraph (2) to be paid on October 1 and April 1 by an importer shall be an amount that is proportional to a reasonable estimate by the Secretary of the semiannual share of the importer of the volume of qualifying drugs imported by importers under subsection (a).

''(4) USE OF FEES.—

''(A) IN GENERAL.—Fees collected by the Secretary under paragraphs (1) and (2) shall be credited to the appropriation account for salaries and expenses of the Food and Drug Administration until expended (without fiscal year limitation), and the Secretary may, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, transfer some proportion of such fees to the appropriation account for salaries and expenses of the Bureau of Customs and Border Protection until expended (without fiscal year limitation).

''(B) AVAILABILITY.—Fees collected by the Secretary under paragraphs (1) and (2) shall be made available to the Food and Drug Administration.

''(C) SOLE PURPOSE.—Fees collected by the Secretary under paragraphs (1) and (2) are only available to the Secretary and, if transferred, to the Secretary of Homeland Security, and are for the sole purpose of paying the costs referred to in paragraph (3)(A).

''(5) COLLECTION OF FEES.—In any case where the Secretary does not receive payment of a fee assessed under paragraph (1) or (2) within 30 days after it is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.

''(f) EXPORTER FEES.—

''(1) REGISTRATION FEE.—A registration condition is that the exporter involved pays to the Secretary a fee of $10,000 due on the date on which the exporter first submits that registration to the Secretary under subsection (b).

''(2) INSPECTION FEE.—A registration condition is that the exporter involved pays a fee to the Secretary in accordance with this subsection. Such fee shall be paid not later than October 1 and April 1 of each fiscal year in the amount provided for under paragraph (3).

''(3) AMOUNT OF INSPECTION FEE.—

''(A) AGGREGATE TOTAL OF FEES.—Not later than 30 days before the start of each fiscal year, the Secretary, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, shall establish an aggregate total of fees to be collected under paragraph (2) for exporters for that fiscal year that is sufficient, and not more than necessary, to pay the costs for that fiscal year of administering this section with respect to registered exporters, including the costs associated with—

''(i) inspecting the facilities of registered exporters, and of other entities in the chain of custody of a qualifying drug as necessary, under subsection (d)(3);

''(ii) developing, implementing, and operating under such subsection a system to screen marks on shipments of qualifying drugs under subsection (a) that indicate compliance with all registration conditions, when such shipments are offered for import into the United States; and

''(iii) screening such markings, and inspecting such shipments as necessary, when offered for import into the United States to determine if such a shipment should be refused admission under subsection (g)(5).

''(B) LIMITATION.—Subject to subparagraph (C), the aggregate total of fees collected under paragraph (2) for a fiscal year shall not exceed 2.5 percent of the total price of qualifying drugs imported during that fiscal year into the United States by registered exporters under subsection (a).

''(C) TOTAL PRICE OF DRUGS.—

''(i) ESTIMATE.—For the purposes of complying with the limitation described in subparagraph (B) when establishing under subparagraph (A) the aggregate total of fees to be collected under paragraph (2) for a fiscal year, the Secretary shall estimate the total price of qualifying drugs imported into the United States by registered exporters during that fiscal year by adding the total price of qualifying drugs exported by each registered exporter during the 6-month period from January 1 through June 30 of the previous fiscal year, as reported to the Secretary by each registered exporter under subsection (b)(1)(I)(iv).

''(ii) CALCULATION.—Not later than March 1 of the fiscal year that follows the fiscal year for which the estimate under clause (i) is made, the Secretary shall calculate the total price of qualifying drugs imported into the United States by registered exporters during that fiscal year by adding the total price of qualifying drugs exported by each registered exporter during that fiscal year, as reported to the Secretary by each registered exporter under subsection (b)(1)(I)(iv).

''(iii) ADJUSTMENT.—If the total price of qualifying drugs imported into the United States by registered exporters during a fiscal year as calculated under clause (ii) is less than the aggregate total of fees collected under paragraph (2) for that fiscal year, the Secretary shall provide for a pro-rata reduction in the fee due from each registered exporter on April 1 of the subsequent fiscal year so that the limitation described in subparagraph (B) is observed.

''(D) INDIVIDUAL EXPORTER FEE.—Subject to the limitation described in subparagraph (B), the fee under paragraph (2) to be paid on October 1 and April 1 by an exporter shall be an amount that is proportional to a reasonable estimate by the Secretary of the semiannual share of the exporter of the volume of qualifying drugs exported by exporters under subsection (a).

''(4) USE OF FEES.—

''(A) IN GENERAL.—Fees collected by the Secretary under paragraphs (1) and (2) shall be credited to the appropriation account for salaries and expenses of the Food and Drug Administration until expended (without fiscal year limitation), and the Secretary may, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, transfer some proportion of such fees to the appropriation account for salaries and expenses of the Bureau of Customs and Border Protection until expended (without fiscal year limitation).

''(B) AVAILABILITY.—Fees collected by the Secretary under paragraphs (1) and (2) shall be made available to the Food and Drug Administration.

''(C) SOLE PURPOSE.—Fees collected by the Secretary under paragraphs (1) and (2) are only available to the Secretary and, if transferred, to the Secretary of Homeland Security, and are for the sole purpose of paying the costs referred to in paragraph (3)(A).

''(5) COLLECTION OF FEES.—In any case where the Secretary does not receive payment of a fee assessed under paragraph (1) or (2) within 30 days after it is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.

''(g) COMPLIANCE WITH SECTION 801(a).—

''(1) IN GENERAL.—A registration condition is that each qualifying drug exported under subsection (a) by the registered exporter involved or imported under subsection (a) by the registered importer involved is in compliance with the standards referred to in section 801(a) regarding admission of the drug into the United States, subject to paragraphs (2), (3), and (4).

''(2) SECTION 505; APPROVAL STATUS.—

''(A) IN GENERAL.—A qualifying drug that is imported or offered for import under subsection (a) shall comply with the conditions established in the approved application under section 505(b) for the U.S. label drug as described under this subsection.

''(B) NOTICE BY MANUFACTURER; GENERAL PROVISIONS.—

''(i) IN GENERAL.—The person that manufactures a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country shall in accordance with this paragraph submit to the Secretary a notice that—

''(I) includes each difference in the qualifying drug from a condition established in the approved application for the U.S. label drug beyond—

''(aa) the variations provided for in the application; and

''(bb) any difference in labeling (except ingredient labeling); or

''(II) states that there is no difference in the qualifying drug from a condition established in the approved application for the U.S. label drug beyond—

''(aa) the variations provided for in the application; and

''(bb) any difference in labeling (except ingredient labeling).

''(ii) INFORMATION IN NOTICE.—A notice under clause (i)(I) shall include the information that the Secretary may require under section 506A, any additional information the Secretary may require (which may include data on bioequivalence if such data are not required under section 506A), and, with respect to the permitted country that approved the qualifying drug for commercial distribution, or with respect to which such approval is sought, include the following:

''(I) The date on which the qualifying drug with such difference was, or will be, introduced for commercial distribution in the permitted country.

''(II) Information demonstrating that the person submitting the notice has also notified the government of the permitted country in writing that the person is submitting to the Secretary a notice under clause (i)(I), which notice describes the difference in the qualifying drug from a condition established in the approved application for the U.S. label drug.

''(III) The information that the person submitted or will submit to the government of the permitted country for purposes of obtaining approval for commercial distribution of the drug in the country which, if in a language other than English, shall be accompanied by an English translation verified to be complete and accurate, with the name, address, and a brief statement of the qualifications of the person that made the translation.

''(iii) CERTIFICATIONS.—The chief executive officer and the chief medical officer of the manufacturer involved shall each certify in the notice under clause (i) that—

''(I) the information provided in the notice is complete and true; and

''(II) a copy of the notice has been provided to the Federal Trade Commission and to the State attorneys general.

''(iv) FEE.—

''(I) IN GENERAL.—If a notice submitted under clause (i) includes a difference that would, under section 506A, require the submission of a supplemental application if made as a change to the U.S. label drug, the person that submits the notice shall pay to the Secretary a fee in the same amount as would apply if the person were paying a fee pursuant to section 736(a)(1)(A)(ii). Fees collected by the Secretary under the preceding sentence are available only to the Secretary and are for the sole purpose of paying the costs of reviewing notices submitted under clause (i).

''(II) FEE AMOUNT FOR CERTAIN YEARS.—If no fee amount is in effect under section 736(a)(1)(A)(ii) for a fiscal year, then the amount paid by a person under subclause (I) shall—

''(aa) for the first fiscal year in which no fee amount under such section in effect, be equal to the fee amount under section 736(a)(1)(A)(ii) for the most recent fiscal year for which such section was in effect, adjusted in accordance with section 736(c); and

''(bb) for each subsequent fiscal year in which no fee amount under such section is effect, be equal to the applicable fee amount for the previous fiscal year, adjusted in accordance with section 736(c).

''(v) TIMING OF SUBMISSION OF NOTICES.—

''(I) PRIOR APPROVAL NOTICES.—A notice under clause (i) to which subparagraph (C) applies shall be submitted to the Secretary not later than 120 days before the qualifying drug with the difference is introduced for commercial distribution in a permitted country, unless the country requires that distribution of the qualifying drug with the difference begin less than 120 days after the country requires the difference.

''(II) OTHER APPROVAL NOTICES.—A notice under clause (i) to which subparagraph (D) applies shall be submitted to the Secretary not later than the day on which the qualifying drug with the difference is introduced for commercial distribution in a permitted country.

''(III) OTHER NOTICES.—A notice under clause (i) to which subparagraph (E) applies shall be submitted to the Secretary on the

date that the qualifying drug is first introduced for commercial distribution in a permitted country and annually thereafter.

''(vi) REVIEW BY SECRETARY.—

''(I) IN GENERAL.—In this paragraph, the difference in a qualifying drug that is submitted in a notice under clause (i) from the U.S. label drug shall be treated by the Secretary as if it were a manufacturing change to the U.S. label drug under section 506A.

''(II) STANDARD OF REVIEW.—Except as provided in subclause (III), the Secretary shall review and approve or disapprove the difference in a notice submitted under clause (i), if required under section 506A, using the safe and effective standard for approving or disapproving a manufacturing change under section 506A.

''(III) BIOEQUIVALENCE.—If the Secretary would approve the difference in a notice submitted under clause (i) using the safe and effective standard under section 506A and if the Secretary determines that the qualifying drug is not bioequivalent to the U.S. label drug, the Secretary shall—

''(aa) include in the labeling provided under paragraph (3) a prominent advisory that the qualifying drug is safe and effective but is not bioequivalent to the U.S. label drug if the Secretary determines that such an advisory is necessary for health care practitioners and patients to use the qualifying drug safely and effectively; or

''(bb) decline to approve the difference if the Secretary determines that the availability of both the qualifying drug and the U.S. label drug would pose a threat to the public health.

''(IV) REVIEW BY THE SECRETARY.—The Secretary shall review and approve or disapprove the difference in a notice submitted under clause (i), if required under section 506A, not later than 120 days after the date on which the notice is submitted.

''(V) ESTABLISHMENT INSPECTION.—If review of such difference would require an inspection of the establishment in which the qualifying drug is manufactured—

''(aa) such inspection by the Secretary shall be authorized; and

''(bb) the Secretary may rely on a satisfactory report of a good manufacturing practice inspection of the establishment from a permitted country whose regulatory system the Secretary recognizes as equivalent under a mutual recognition agreement, as provided under section 510(i)(3), section 803, or part 26 of title 21, Code of Federal Regulations (or any corresponding successor rule or regulation).

''(vii) PUBLICATION OF INFORMATION ON NOTICES.—

''(I) IN GENERAL.—Through the Internet website of the Food and Drug Administration and a toll-free telephone number, the Secretary shall readily make available to the public a list of notices submitted under clause (i).

''(II) CONTENTS.—The list under subclause (I) shall include the date on which a notice is submitted and whether—

''(aa) a notice is under review;

''(bb) the Secretary has ordered that importation of the qualifying drug from a permitted country cease; or

''(cc) the importation of the drug is permitted under subsection (a).

''(III) UPDATE.—The Secretary shall promptly update the Internet website with any changes to the list.

''(C) NOTICE; DRUG DIFFERENCE REQUIRING PRIOR APPROVAL.—In the case of a notice under subparagraph (B)(i) that includes a difference that would, under subsection (c) or (d)(3)(B)(i) of section 506A, require the approval of a supplemental application before the difference could be made to the U.S. label drug the following shall occur:

''(i) Promptly after the notice is submitted, the Secretary shall notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general that the notice has been submitted with respect to the qualifying drug involved.

''(ii) If the Secretary has not made a determination whether such a supplemental application regarding the U.S. label drug would be approved or disapproved by the date on which the qualifying drug involved is to be introduced for commercial distribution in a permitted country, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country not begin until the Secretary completes review of the notice; and

''(II) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the order.

''(iii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would not be approved, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country cease, or provide that an order under clause (ii), if any, remains in effect;

''(II) notify the permitted country that approved the qualifying drug for commercial distribution of the determination; and

''(III) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(iv) If the Secretary determines that such a supplemental application regarding the U.S. label drug would be approved, the Secretary shall—

''(I) vacate the order under clause (ii), if any;

''(II) consider the difference to be a variation provided for in the approved application for the U.S. label drug;

''(III) permit importation of the qualifying drug under subsection (a); and

''(IV) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(D) NOTICE; DRUG DIFFERENCE NOT REQUIRING PRIOR APPROVAL.—In the case of a notice under subparagraph (B)(i) that includes a difference that would, under section 506A(d)(3)(B)(ii), not require the approval of a supplemental application before the difference could be made to the U.S. label drug the following shall occur:

''(i) During the period in which the notice is being reviewed by the Secretary, the authority under this subsection to import the qualifying drug involved continues in effect.

''(ii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would not be approved, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country cease;

''(II) notify the permitted country that approved the qualifying drug for commercial distribution of the determination; and

''(III) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(iii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would be approved, the difference shall be considered to be a variation provided for in the approved application for the U.S. label drug.

''(E) NOTICE; DRUG DIFFERENCE NOT REQUIRING APPROVAL; NO DIFFERENCE.—In the case of a notice under subparagraph (B)(i) that includes a difference for which, under section 506A(d)(1)(A), a supplemental application would not be required for the difference to be made to the U.S. label drug, or that states that there is no difference, the Secretary—

''(i) shall consider such difference to be a variation provided for in the approved application for the U.S. label drug;

''(ii) may not order that the importation of the qualifying drug involved cease; and

''(iii) shall promptly notify registered exporters and registered importers.

''(F) DIFFERENCES IN ACTIVE INGREDIENT, ROUTE OF ADMINISTRATION, DOSAGE FORM, OR STRENGTH.—

''(i) IN GENERAL.—A person who manufactures a drug approved under section 505(b) shall submit an application under section 505(b) for approval of another drug that is manufactured for distribution in a permitted country by or for the person that manufactures the drug approved under section 505(b) if—

''(I) there is no qualifying drug in commercial distribution in permitted countries whose combined population represents at least 50 percent of the total population of all permitted countries with the same active ingredient or ingredients, route of administration, dosage form, and strength as the drug approved under section 505(b); and

''(II) each active ingredient of the other drug is related to an active ingredient of the drug approved under section 505(b), as defined in clause (v).

''(ii) APPLICATION UNDER SECTION 505(b).—The application under section 505(b) required under clause (i) shall—

''(I) request approval of the other drug for the indication or indications for which the drug approved under section 505(b) is labeled;

''(II) include the information that the person submitted to the government of the permitted country for purposes of obtaining approval for commercial distribution of the other drug in that country, which if in a language other than English, shall be accompanied by an English translation verified to be complete and accurate, with the name, address, and a brief statement of the qualifications of the person that made the translation;

''(III) include a right of reference to the application for the drug approved under section 505(b); and

''(IV) include such additional information as the Secretary may require.

''(iii) TIMING OF SUBMISSION OF APPLICATION.—An application under section 505(b) required under clause (i) shall be submitted to the Secretary not later than the day on which the information referred to in clause (ii)(II) is submitted to the government of the permitted country.

''(iv) NOTICE OF DECISION ON APPLICATION.—The Secretary shall promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of a determination to approve or to disapprove an application under section 505(b) required under clause (i).

''(v) RELATED ACTIVE INGREDIENTS.—For purposes of clause (i)(II), 2 active ingredients are related if they are—

''(I) the same; or

''(II) different salts, esters, or complexes of the same moiety.

''(3) SECTION 502; LABELING.—

''(A) IMPORTATION BY REGISTERED IMPORTER.—

''(i) IN GENERAL.—In the case of a qualifying drug that is imported or offered for import by a registered importer, such drug shall be considered to be in compliance with section 502 and the labeling requirements under the approved application for the U.S. label drug if the qualifying drug bears—

''(I) a copy of the labeling approved for the U.S. label drug under section 505, without regard to whether the copy bears any trademark involved;

''(II) the name of the manufacturer and location of the manufacturer;

''(III) the lot number assigned by the manufacturer;

''(IV) the name, location, and registration number of the importer; and

''(V) the National Drug Code number assigned to the qualifying drug by the Secretary.

''(ii) REQUEST FOR COPY OF THE LABELING.—The Secretary shall provide such copy to the registered importer involved, upon request of the importer.

''(iii) REQUESTED LABELING.—The labeling provided by the Secretary under clause (ii) shall—

''(I) include the established name, as defined in section 502(e)(3), for each active ingredient in the qualifying drug;

''(II) not include the proprietary name of the U.S. label drug or any active ingredient thereof;

''(III) if required under paragraph (2)(B)(vi)(III), a prominent advisory that the qualifying drug is safe and effective but not bioequivalent to the U.S. label drug; and

''(IV) if the inactive ingredients of the qualifying drug are different from the inactive ingredients for the U.S. label drug, include—

''(aa) a prominent notice that the ingredients of the qualifying drug differ from the ingredients of the U.S. label drug and that the qualifying drug must be dispensed with an advisory to people with allergies about this difference and a list of ingredients; and

''(bb) a list of the ingredients of the qualifying drug as would be required under section 502(e).

''(B) IMPORTATION BY INDIVIDUAL.—

''(i) IN GENERAL.—In the case of a qualifying drug that is imported or offered for import by a registered exporter to an individual, such drug shall be considered to be in compliance with section 502 and the labeling requirements under the approved application for the U.S. label drug if the packaging and labeling of the qualifying drug complies with all applicable regulations promulgated under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.) and the labeling of the qualifying drug includes—

''(I) directions for use by the consumer;

''(II) the lot number assigned by the manufacturer;

''(III) the name and registration number of the exporter;

''(IV) if required under paragraph (2)(B)(vi)(III), a prominent advisory that the drug is safe and effective but not bioequivalent to the U.S. label drug;

''(V) if the inactive ingredients of the drug are different from the inactive ingredients for the U.S. label drug—

''(aa) a prominent advisory that persons with an allergy should check the ingredient list of the drug because the ingredients of the drug differ from the ingredients of the U.S. label drug; and

''(bb) a list of the ingredients of the drug as would be required under section 502(e); and

''(VI) a copy of any special labeling that would be required by the Secretary had the U.S. label drug been dispensed by a pharmacist in the United States, without regard to whether the special labeling bears any trademark involved.

''(ii) PACKAGING.—A qualifying drug offered for import to an individual by an exporter under this section that is packaged in a unit-of-use container (as those items are defined in the United States Pharmacopeia and National Formulary) shall not be repackaged, provided that—

''(I) the packaging complies with all applicable regulations under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.); or

''(II) the consumer consents to waive the requirements of such Act, after being informed that the packaging does not comply with such Act and that the exporter will provide the drug in packaging that is compliant at no additional cost.

''(iii) REQUEST FOR COPY OF SPECIAL LABELING AND INGREDIENT LIST.—The Secretary shall provide to the registered exporter involved a copy of the special labeling, the advisory, and the ingredient list described under clause (i), upon request of the exporter.

''(iv) REQUESTED LABELING AND INGREDIENT LIST.—The labeling and ingredient list provided by the Secretary under clause (iii) shall—

''(I) include the established name, as defined in section 502(e)(3), for each active ingredient in the drug; and

''(II) not include the proprietary name of the U.S. label drug or any active ingredient thereof.

''(4) SECTION 501; ADULTERATION.—A qualifying drug that is imported or offered for import under subsection (a) shall be considered to be in compliance with section 501 if the drug is in compliance with subsection (c).

''(5) STANDARDS FOR REFUSING ADMISSION.—A drug exported under subsection (a) from a registered exporter or imported by a registered importer may be refused admission into the United States if 1 or more of the following applies:

''(A) The drug is not a qualifying drug.

''(B) A notice for the drug required under paragraph (2)(B) has not been submitted to the Secretary.

''(C) The Secretary has ordered that importation of the drug from the permitted country cease under subparagraph (C) or (D) of paragraph (2).

''(D) The drug does not comply with paragraph (3) or (4).

''(E) The shipping container appears damaged in a way that may affect the strength, quality, or purity of the drug.

''(F) The Secretary becomes aware that—

''(i) the drug may be counterfeit;

''(ii) the drug may have been prepared, packed, or held under insanitary conditions; or

''(iii) the methods used in, or the facilities or controls used for, the manufacturing, processing, packing, or holding of the drug do not conform to good manufacturing practice.

''(G) The Secretary has obtained an injunction under section 302 that prohibits the distribution of the drug in interstate commerce.

''(H) The Secretary has under section 505(e) withdrawn approval of the drug.

''(I) The manufacturer of the drug has instituted a recall of the drug.

''(J) If the drug is imported or offered for import by a registered importer without submission of a notice in accordance with subsection (d)(4).

''(K) If the drug is imported or offered for import from a registered exporter to an individual and 1 or more of the following applies:

''(i) The shipping container for such drug does not bear the markings required under subsection (d)(2).

''(ii) The markings on the shipping container appear to be counterfeit.

''(iii) The shipping container or markings appear to have been tampered with.

''(h) EXPORTER LICENSURE IN PERMITTED COUNTRY.—A registration condition is that the exporter involved agrees that a qualifying drug will be exported to an individual only if the Secretary has verified that—

''(1) the exporter is authorized under the law of the permitted country in which the exporter is located to dispense prescription drugs; and

''(2) the exporter employs persons that are licensed under the law of the permitted country in which the exporter is located to dispense prescription drugs in sufficient number to dispense safely the drugs exported by the exporter to individuals, and the exporter assigns to those persons responsibility for dispensing such drugs to individuals.

''(i) INDIVIDUALS; CONDITIONS FOR IMPORTATION.—

''(1) IN GENERAL.—For purposes of subsection (a)(2)(B), the importation of a qualifying drug by an individual is in accordance with this subsection if the following conditions are met:

''(A) The drug is accompanied by a copy of a prescription for the drug, which prescription—

''(i) is valid under applicable Federal and State laws; and

''(ii) was issued by a practitioner who, under the law of a State of which the individual is a resident, or in which the individual receives care from the practitioner who issues the prescription, is authorized to administer prescription drugs.

''(B) The drug is accompanied by a copy of the documentation that was required under the law or regulations of the permitted country in which the exporter is located, as a condition of dispensing the drug to the individual.

''(C) The copies referred to in subparagraphs (A)(i) and (B) are marked in a manner sufficient—

''(i) to indicate that the prescription, and the equivalent document in the permitted country in which the exporter is located, have been filled; and

''(ii) to prevent a duplicative filling by another pharmacist.

''(D) The individual has provided to the registered exporter a complete list of all drugs used by the individual for review by the individuals who dispense the drug.

''(E) The quantity of the drug does not exceed a 90-day supply.

''(F) The drug is not an ineligible subpart H drug. For purposes of this section, a prescription drug is an 'ineligible subpart H drug' if the drug was approved by the Secretary under subpart H of part 314 of title 21, Code of Federal Regulations (relating to accelerated approval), with restrictions under section 520 of such part to assure safe use, and the Secretary has published in the Federal Register a notice that the Secretary has determined that good cause exists to prohibit the drug from being imported pursuant to this subsection.

''(2) NOTICE REGARDING DRUG REFUSED ADMISSION.—If a registered exporter ships a drug to an individual pursuant to subsection (a)(2)(B) and the drug is refused admission to the United States, a written notice shall be sent to the individual and to the exporter that informs the individual and the exporter of such refusal and the reason for the refusal.

''(j) MAINTENANCE OF RECORDS AND SAMPLES.—

''(1) IN GENERAL.—A registration condition is that the importer or exporter involved shall—

''(A) maintain records required under this section for not less than 2 years; and

''(B) maintain samples of each lot of a qualifying drug required under this section for not more than 2 years.

''(2) PLACE OF RECORD MAINTENANCE.—The records described under paragraph (1) shall be maintained—

''(A) in the case of an importer, at the place of business of the importer at which the importer initially receives the qualifying drug after importation; or

''(B) in the case of an exporter, at the facility from which the exporter ships the qualifying drug to the United States.

''(k) DRUG RECALLS.—

''(1) MANUFACTURERS.—A person that manufactures a qualifying drug imported from a permitted country under this section shall promptly inform the Secretary—

''(A) if the drug is recalled or withdrawn from the market in a permitted country;

''(B) how the drug may be identified, including lot number; and

''(C) the reason for the recall or withdrawal.

''(2) SECRETARY.—With respect to each permitted country, the Secretary shall—

''(A) enter into an agreement with the government of the country to receive information about recalls and withdrawals of qualifying drugs in the country; or

''(B) monitor recalls and withdrawals of qualifying drugs in the country using any information that is available to the public in any media.

''(3) NOTICE.—The Secretary may notify, as appropriate, registered exporters, registered importers, wholesalers, pharmacies, or the public of a recall or withdrawal of a qualifying drug in a permitted country.

''(l) DRUG LABELING AND PACKAGING.—

''(1) IN GENERAL.—When a qualifying drug that is imported into the United States by an importer under subsection (a) is dispensed by a pharmacist to an individual, the pharmacist shall provide that the packaging and labeling of the drug complies with all applicable regulations promulgated under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.) and shall include with any other labeling provided to the individual the following:

''(A) The lot number assigned by the manufacturer.

''(B) The name and registration number of the importer.

''(C) If required under paragraph (2)(B)(vi)(III) of subsection (g), a prominent advisory that the drug is safe and effective but not bioequivalent to the U.S. label drug.

''(D) If the inactive ingredients of the drug are different from the inactive ingredients for the U.S. label drug—

''(i) a prominent advisory that persons with allergies should check the ingredient list of the drug because the ingredients of the drug differ from the ingredients of the U.S. label drug; and

''(ii) a list of the ingredients of the drug as would be required under section 502(e).

''(2) PACKAGING.—A qualifying drug that is packaged in a unit-of-use container (as those terms are defined in the United States Pharmacopeia and National Formulary) shall not be repackaged, provided that—

''(A) the packaging complies with all applicable regulations under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.); or

''(B) the consumer consents to waive the requirements of such Act, after being informed that the packaging does not comply with such Act and that the pharmacist will provide the drug in packaging that is compliant at no additional cost.

''(m) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, this section does not authorize the importation into the United States of a qualifying drug donated or otherwise supplied for free or at nominal cost by the manufacturer of the drug to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country.

''(n) UNFAIR AND DISCRIMINATORY ACTS AND PRACTICES.—

''(1) IN GENERAL.—It is unlawful for a manufacturer, directly or indirectly (including by being a party to a licensing agreement or other agreement), to—

''(A) discriminate by charging a higher price for a prescription drug sold to a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section than the price that is charged, inclusive of rebates or other incentives to the permitted country or other person, to another person that is in the same country and that does not export a qualifying drug into the United States under this section;

''(B) discriminate by charging a higher price for a prescription drug sold to a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section than the price that is charged to another person in the United States that does not import a qualifying drug under this section, or that does not distribute, sell, or use such a drug;

''(C) discriminate by denying, restricting, or delaying supplies of a prescription drug to a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section or to a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section;

''(D) discriminate by publicly, privately, or otherwise refusing to do business with a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section or with a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section;

''(E) knowingly fail to submit a notice under subsection (g)(2)(B)(i), knowingly fail to submit such a notice on or before the date specified in subsection (g)(2)(B)(v) or as otherwise required under paragraphs (3), (4), and (5) of section 10004(e) of the Pharmaceutical Market Access and Drug Safety Act of 2009, knowingly submit such a notice that makes a materially false, fictitious, or fraudulent statement, or knowingly fail to provide promptly any information requested by the Secretary to review such a notice;

''(F) knowingly fail to submit an application required under subsection (g)(2)(F), knowingly fail to submit such an application on or before the date specified in subsection (g)(2)(F)(iii), knowingly submit such an application that makes a materially false, fictitious, or fraudulent statement, or knowingly fail to provide promptly any information requested by the Secretary to review such an application;

''(G) cause there to be a difference (including a difference in active ingredient, route of administration, dosage form, strength, formulation, manufacturing establishment, manufacturing process, or person that manufactures the drug) between a prescription drug for distribution in the United States and the drug for distribution in a permitted country;

''(H) refuse to allow an inspection authorized under this section of an establishment that manufactures a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country;

''(I) fail to conform to the methods used in, or the facilities used for, the manufacturing, processing, packing, or holding of a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country to good manufacturing practice under this Act;

''(J) become a party to a licensing agreement or other agreement related to a qualifying drug that fails to provide for compliance with all requirements of this section with respect to such drug;

''(K) enter into a contract that restricts, prohibits, or delays the importation of a qualifying drug under this section;

''(L) engage in any other action to restrict, prohibit, or delay the importation of a qualifying drug under this section; or

''(M) engage in any other action that the Federal Trade Commission determines to discriminate against a person that engages or attempts to engage in the importation of a qualifying drug under this section.

''(2) REFERRAL OF POTENTIAL VIOLATIONS.—The Secretary shall promptly refer to the Federal Trade Commission each potential violation of subparagraph (E), (F), (G), (H), or (I) of paragraph (1) that becomes known to the Secretary.

''(3) AFFIRMATIVE DEFENSE.—

''(A) DISCRIMINATION.—It shall be an affirmative defense to a charge that a manufacturer has discriminated under subparagraph (A), (B), (C), (D), or (M) of paragraph (1) that the higher price charged for a prescription drug sold to a person, the denial, restriction, or delay of supplies of a prescription drug to a person, the refusal to do business with a person, or other discriminatory activity against a person, is not based, in whole or in part, on—

''(i) the person exporting or importing a qualifying drug into the United States under this section; or

''(ii) the person distributing, selling, or using a qualifying drug imported into the United States under this section.

''(B) DRUG DIFFERENCES.—It shall be an affirmative defense to a charge that a manufacturer has caused there to be a difference described in subparagraph (G) of paragraph (1) that—

''(i) the difference was required by the country in which the drug is distributed;

''(ii) the Secretary has determined that the difference was necessary to improve the safety or effectiveness of the drug;

''(iii) the person manufacturing the drug for distribution in the United States has given notice to the Secretary under subsection (g)(2)(B)(i) that the drug for distribution in the United States is not different from a drug for distribution in permitted countries whose combined population represents at least 50 percent of the total population of all permitted countries; or

''(iv) the difference was not caused, in whole or in part, for the purpose of restricting importation of the drug into the United States under this section.

''(4) EFFECT OF SUBSECTION.—

''(A) SALES IN OTHER COUNTRIES.—This subsection applies only to the sale or distribution of a prescription drug in a country if the manufacturer of the drug chooses to sell or distribute the drug in the country. Nothing in this subsection shall be construed to compel the manufacturer of a drug to distribute or sell the drug in a country.

''(B) DISCOUNTS TO INSURERS, HEALTH PLANS, PHARMACY BENEFIT MANAGERS, AND COVERED ENTITIES.—Nothing in this subsection shall be construed to—

''(i) prevent or restrict a manufacturer of a prescription drug from providing discounts to an insurer, health plan, pharmacy benefit manager in the United States, or covered entity in the drug discount program under section 340B of the Public Health Service Act (42 U.S.C. 256b) in return for inclusion of the drug on a formulary;

''(ii) require that such discounts be made available to other purchasers of the prescription drug; or

''(iii) prevent or restrict any other measures taken by an insurer, health plan, or pharmacy benefit manager to encourage consumption of such prescription drug.

''(C) CHARITABLE CONTRIBUTIONS.—Nothing in this subsection shall be construed to—

''(i) prevent a manufacturer from donating a prescription drug, or supplying a prescription drug at nominal cost, to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country; or

''(ii) apply to such donations or supplying of a prescription drug.

''(5) ENFORCEMENT.—

''(A) UNFAIR OR DECEPTIVE ACT OR PRACTICE.—A violation of this subsection shall be treated as a violation of a rule defining an unfair or deceptive act or practice prescribed under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

''(B) ACTIONS BY THE COMMISSION.—The Federal Trade Commission—

''(i) shall enforce this subsection in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this section; and

''(ii) may seek monetary relief threefold the damages sustained, in addition to any other remedy available to the Federal Trade Commission under the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

''(6) ACTIONS BY STATES.—

''(A) IN GENERAL.—

''(i) CIVIL ACTIONS.—In any case in which the attorney general of a State has reason to believe that an interest of the residents of that State have been adversely affected by any manufacturer that violates paragraph (1), the attorney general of a State may bring a civil action on behalf of the residents of the State, and persons doing business in the State, in a district court of the United States of appropriate jurisdiction to—

''(I) enjoin that practice;

''(II) enforce compliance with this subsection;

''(III) obtain damages, restitution, or other compensation on behalf of residents of the State and persons doing business in the State, including threefold the damages; or

''(IV) obtain such other relief as the court may consider to be appropriate.

''(ii) NOTICE.—

''(I) IN GENERAL.—Before filing an action under clause (i), the attorney general of the State involved shall provide to the Federal Trade Commission—

''(aa) written notice of that action; and

''(bb) a copy of the complaint for that action.

''(II) EXEMPTION.—Subclause (I) shall not apply with respect to the filing of an action by an attorney general of a State under this paragraph, if the attorney general determines that it is not feasible to provide the notice described in that subclause before filing of the action. In such case, the attorney general of a State shall provide notice and a copy of the complaint to the Federal Trade Commission at the same time as the attorney general files the action.

''(B) INTERVENTION.—

''(i) IN GENERAL.—On receiving notice under subparagraph (A)(ii), the Federal Trade Commission shall have the right to intervene in the action that is the subject of the notice.

''(ii) EFFECT OF INTERVENTION.—If the Federal Trade Commission intervenes in an action under subparagraph (A), it shall have the right—

''(I) to be heard with respect to any matter that arises in that action; and

''(II) to file a petition for appeal.

''(C) CONSTRUCTION.—For purposes of bringing any civil action under subparagraph (A), nothing in this subsection shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State to—

''(i) conduct investigations;

''(ii) administer oaths or affirmations; or

''(iii) compel the attendance of witnesses or the production of documentary and other evidence.

''(D) ACTIONS BY THE COMMISSION.—In any case in which an action is instituted by or on behalf of the Federal Trade Commission for a violation of paragraph (1), a State may not, during the pendency of that action, institute an action under subparagraph (A) for the same violation against any defendant named in the complaint in that action.

''(E) VENUE.—Any action brought under subparagraph (A) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

''(F) SERVICE OF PROCESS.—In an action brought under subparagraph (A), process may be served in any district in which the defendant—

''(i) is an inhabitant; or

''(ii) may be found.

''(G) MEASUREMENT OF DAMAGES.—In any action under this paragraph to enforce a cause of action under this subsection in which there has been a determination that a defendant has violated a provision of this subsection, damages may be proved and assessed in the aggregate by statistical or sampling methods, by the computation of illegal overcharges or by such other reasonable system of estimating aggregate damages as the court in its discretion may permit without the necessity of separately proving the individual claim of, or amount of damage to, persons on whose behalf the suit was brought.

''(H) EXCLUSION ON DUPLICATIVE RELIEF.—The district court shall exclude from the amount of monetary relief awarded in an action under this paragraph brought by the attorney general of a State any amount of monetary relief which duplicates amounts which have been awarded for the same injury.

''(7) EFFECT ON ANTITRUST LAWS.—Nothing in this subsection shall be construed to modify, impair, or supersede the operation of the antitrust laws. For the purpose of this subsection, the term 'antitrust laws' has the meaning given it in the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

''(8) MANUFACTURER.—In this subsection, the term 'manufacturer' means any entity, including any affiliate or licensee of that entity, that is engaged in—

''(A) the production, preparation, propagation, compounding, conversion, or processing of a prescription drug, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or

''(B) the packaging, repackaging, labeling, relabeling, or distribution of a prescription drug.''.

(b) PROHIBITED ACTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301 (21 U.S.C. 331), by striking paragraph (aa) and inserting the following:

''(aa)(1) The sale or trade by a pharmacist, or by a business organization of which the pharmacist is a part, of a qualifying drug that under section 804(a)(2)(A) was imported by the pharmacist, other than—

''(A) a sale at retail made pursuant to dispensing the drug to a customer of the pharmacist or organization; or

''(B) a sale or trade of the drug to a pharmacy or a wholesaler registered to import drugs under section 804.

''(2) The sale or trade by an individual of a qualifying drug that under section 804(a)(2)(B) was imported by the individual.

''(3) The making of a materially false, fictitious, or fraudulent statement or representation, or a material omission, in a notice under clause (i) of section 804(g)(2)(B) or in an application required under section 804(g)(2)(F), or the failure to submit such a notice or application.

''(4) The importation of a drug in violation of a registration condition or other requirement under section 804, the falsification of any record required to be maintained, or provided to the Secretary, under such section, or the violation of any registration condition or other requirement under such section.''; and

(2) in section 303(a) (21 U.S.C. 333(a)), by striking paragraph (6) and inserting the following:

''(6) Notwithstanding subsection (a), any person that knowingly violates section 301(i)(2) or (3) or section 301(aa)(4) shall be imprisoned not more than 10 years, or fined in accordance with title 18, United States Code, or both.''.

(c) AMENDMENT OF CERTAIN PROVISIONS.—

(1) IN GENERAL.—Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381) is amended by striking subsection (g) and inserting the following:

''(g) With respect to a prescription drug that is imported or offered for import into the United States by an individual who is not in the business of such importation, that is not shipped by a registered exporter under section 804, and that is refused admission under subsection (a), the Secretary shall notify the individual that—

''(1) the drug has been refused admission because the drug was not a lawful import under section 804;

''(2) the drug is not otherwise subject to a waiver of the requirements of subsection (a);

''(3) the individual may under section 804 lawfully import certain prescription drugs from exporters registered with the Secretary under section 804; and

''(4) the individual can find information about such importation, including a list of registered exporters, on the Internet website of the Food and Drug Administration or through a toll-free telephone number required under section 804.''.

(2) ESTABLISHMENT REGISTRATION.—Section 510(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(i)) is amended in paragraph (1) by inserting after ''import into the United States'' the following: '', including a drug that is, or may be, imported or offered for import into the United States under section 804,''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 90 days after the date of enactment of this Act.

(d) EXHAUSTION.—

(1) IN GENERAL.—Section 271 of title 35, United States Code, is amended—

(A) by redesignating subsections (h) and (i) as (i) and (j), respectively; and

(B) by inserting after subsection (g) the following:

''(h) It shall not be an act of infringement to use, offer to sell, or sell within the United States or to import into the United States any patented invention under section 804 of the Federal Food, Drug, and Cosmetic Act that was first sold abroad by or under authority of the owner or licensee of such patent.''.

(2) RULE OF CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the ability of a patent owner or licensee to enforce their patent, subject to such amendment.

(e) EFFECT OF SECTION 804.—

(1) IN GENERAL.—Section 804 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall permit the importation of qualifying drugs (as defined in such section 804) into the United States without regard to the status of the issuance of implementing regulations—

(A) from exporters registered under such section 804 on the date that is 90 days after the date of enactment of this Act; and

(B) from permitted countries, as defined in such section 804, by importers registered under such section 804 on the date that is 1 year after the date of enactment of this Act.

(2) REVIEW OF REGISTRATION BY CERTAIN EXPORTERS.—

(A) REVIEW PRIORITY.—In the review of registrations submitted under subsection (b) of such section 804, registrations submitted by entities in Canada that are significant exporters of prescription drugs to individuals in the United States as of the date of enactment of this Act will have priority during the 90 day period that begins on such date of enactment.

(B) PERIOD FOR REVIEW.—During such 90-day period, the reference in subsection (b)(2)(A) of such section 804 to 90 days (relating to approval or disapproval of registrations) is, as applied to such entities, deemed to be 30 days.

(C) LIMITATION.—That an exporter in Canada exports, or has exported, prescription drugs to individuals in the United States on or before the date that is 90 days after the date of enactment of this Act shall not serve as a basis, in whole or in part, for disapproving a registration under such section 804 from the exporter.

(D) FIRST YEAR LIMIT ON NUMBER OF EXPORTERS.—During the 1-year period beginning on the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') may limit the number of registered exporters under such section 804 to not less than 50, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(E) SECOND YEAR LIMIT ON NUMBER OF EXPORTERS.—During the 1-year period beginning on the date that is 1 year after the date of enactment of this Act, the Secretary may limit the number of registered exporters under such section 804 to not less than 100, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(F) FURTHER LIMIT ON NUMBER OF EXPORTERS.—During any 1-year period beginning on a date that is 2 or more years after the date of enactment of this Act, the Secretary may limit the number of registered exporters under such section 804 to not less than 25 more than the number of such exporters during the previous 1-year period, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(3) LIMITS ON NUMBER OF IMPORTERS.—

(A) FIRST YEAR LIMIT ON NUMBER OF IMPORTERS.—During the 1-year period beginning on the date that is 1 year after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 100 (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups), so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs imported into the United States.

(B) SECOND YEAR LIMIT ON NUMBER OF IMPORTERS.—During the 1-year period beginning on the date that is 2 years after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 200 (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups), so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs into the United States.

(C) FURTHER LIMIT ON NUMBER OF IMPORTERS.—During any 1-year period beginning on a date that is 3 or more years after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 50 more (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups) than the number of such importers during the previous 1-year period, so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs to the United States.

(4) NOTICES FOR DRUGS FOR IMPORT FROM CANADA.—The notice with respect to a qualifying drug introduced for commercial distribution in Canada as of the date of enactment of this Act that is required under subsection (g)(2)(B)(i) of such section 804 shall be submitted to the Secretary not later than 30 days after the date of enactment of this Act if—

(A) the U.S. label drug (as defined in such section 804) for the qualifying drug is 1 of the 100 prescription drugs with the highest dollar volume of sales in the United States based on the 12 calendar month period most recently completed before the date of enactment of this Act; or

(B) the notice is a notice under subsection (g)(2)(B)(i)(II) of such section 804.

(5) NOTICE FOR DRUGS FOR IMPORT FROM OTHER COUNTRIES.—The notice with respect to a qualifying drug introduced for commercial distribution in a permitted country other than Canada as of the date of enactment of this Act that is required under subsection (g)(2)(B)(i) of such section 804 shall be submitted to the Secretary not later than 180 days after the date of enactment of this Act if—

(A) the U.S. label drug for the qualifying drug is 1 of the 100 prescription drugs with the highest dollar volume of sales in the United States based on the 12 calendar month period that is first completed on the date that is 120 days after the date of enactment of this Act; or

(B) the notice is a notice under subsection (g)(2)(B)(i)(II) of such section 804.

(6) NOTICE FOR OTHER DRUGS FOR IMPORT.—

(A) GUIDANCE ON SUBMISSION DATES.—The Secretary shall by guidance establish a series of submission dates for the notices under subsection (g)(2)(B)(i) of such section 804 with respect to qualifying drugs introduced for commercial distribution as of the date of enactment of this Act and that are not required to be submitted under paragraph (4) or (5).

(B) CONSISTENT AND EFFICIENT USE OF RESOURCES.—The Secretary shall establish the dates described under subparagraph (A) so that such notices described under subparagraph (A) are submitted and reviewed at a rate that allows consistent and efficient use of the resources and staff available to the Secretary for such reviews. The Secretary may condition the requirement to submit such a notice, and the review of such a notice, on the submission by a registered exporter or a registered importer to the Secretary of a notice that such exporter or importer intends to import such qualifying drug to the United States under such section 804.

(C) PRIORITY FOR DRUGS WITH HIGHER SALES.—The Secretary shall establish the dates described under subparagraph (A) so that the Secretary reviews the notices described under such subparagraph with respect to qualifying drugs with higher dollar volume of sales in the United States before the notices with respect to drugs with lower sales in the United States.

(7) NOTICES FOR DRUGS APPROVED AFTER EFFECTIVE DATE.—The notice required under subsection (g)(2)(B)(i) of such section 804 for a qualifying drug first introduced for commercial distribution in a permitted country (as defined in such section 804) after the date of enactment of this Act shall be submitted to and reviewed by the Secretary as provided under subsection (g)(2)(B) of such section 804, without regard to paragraph (4), (5), or (6).

(8) REPORT.—Beginning with the first full fiscal year after the date of enactment of this Act, not later than 90 days after the end of each fiscal year during which the Secretary reviews a notice referred to in paragraph (4), (5), or (6), the Secretary shall submit a report to Congress concerning the progress of the Food and Drug Administration in reviewing the notices referred to in paragraphs (4), (5), and (6).

(9) USER FEES.—

(A) EXPORTERS.—When establishing an aggregate total of fees to be collected from exporters under subsection (f)(2) of such section 804, the Secretary shall, under subsection (f)(3)(C)(i) of such section 804, estimate the total price of drugs imported under subsection (a) of such section 804 into the United States by registered exporters during the first fiscal year in which this title takes effect to be an amount equal to the amount which bears the same ratio to $1,000,000,000 as the number of days in such fiscal year during which this title is effective bears to 365.

(B) IMPORTERS.—When establishing an aggregate total of fees to be collected from importers under subsection (e)(2) of such section 804, the Secretary shall, under subsection (e)(3)(C)(i) of such section 804, estimate the total price of drugs imported under subsection (a) of such section 804 into the United States by registered importers during—

(i) the first fiscal year in which this title takes effect to be an amount equal to the amount which bears the same ratio to $1,000,000,000 as the number of days in such fiscal year during which this title is effective bears to 365; and

(ii) the second fiscal year in which this title is in effect to be $3,000,000,000.

(C) SECOND YEAR ADJUSTMENT.—

(i) REPORTS.—Not later than February 20 of the second fiscal year in which this title is in effect, registered importers shall report to the Secretary the total price and the total volume of drugs imported to the United States by the importer during the 4-month period from October 1 through January 31 of such fiscal year.

(ii) REESTIMATE.—Notwithstanding subsection (e)(3)(C)(ii) of such section 804 or subparagraph (B), the Secretary shall reestimate the total price of qualifying drugs imported under subsection (a) of such section 804 into the United States by registered importers during the second fiscal year in which this title is in effect. Such reestimate shall be equal to—

(I) the total price of qualifying drugs imported by each importer as reported under clause (i); multiplied by

(II) 3.

(iii) ADJUSTMENT.—The Secretary shall adjust the fee due on April 1 of the second fiscal year in which this title is in effect, from each importer so that the aggregate total of fees collected under subsection (e)(2) for such fiscal year does not exceed the total price of qualifying drugs imported under subsection (a) of such section 804 into the United States by registered importers during such fiscal year as reestimated under clause (ii).

(D) FAILURE TO PAY FEES.—Notwithstanding any other provision of this section, the Secretary may prohibit a registered importer or exporter that is required to pay user fees under subsection (e) or (f) of such section 804 and that fails to pay such fees within 30 days after the date on which it is due, from importing or offering for importation a qualifying drug under such section 804 until such fee is paid.

(E) ANNUAL REPORT.—

(i) FOOD AND DRUG ADMINISTRATION.—Not later than 180 days after the end of each fiscal year during which fees are collected under subsection (e), (f), or (g)(2)(B)(iv) of such section 804, the Secretary shall prepare and submit to the House of Representatives and the Senate a report on the implementation of the authority for such fees during such fiscal year and the use, by the Food and Drug Administration, of the fees collected for the fiscal year for which the report is made and credited to the Food and Drug Administration.

(ii) CUSTOMS AND BORDER PROTECTION.—Not later than 180 days after the end of each fiscal year during which fees are collected under subsection (e) or (f) of such section 804, the Secretary of Homeland Security, in consultation with the Secretary of the Treasury, shall prepare and submit to the House of Representatives and the Senate a report on the use, by the Bureau of Customs and Border Protection, of the fees, if any, transferred by the Secretary to the Bureau of Customs and Border Protection for the fiscal year for which the report is made.

(10) SPECIAL RULE REGARDING IMPORTATION BY INDIVIDUALS.—

(A) IN GENERAL.—Notwithstanding any provision of this title (or an amendment made by this title), the Secretary shall expedite the designation of any additional permitted countries from which an individual may import a qualifying drug into the United States under such section 804 if any action implemented by the Government of Canada has the effect of limiting or prohibiting the importation of qualifying drugs into the United States from Canada.

(B) TIMING AND CRITERIA.—The Secretary shall designate such additional permitted countries under subparagraph (A)—

(i) not later than 6 months after the date of the action by the Government of Canada described under such subparagraph; and

(ii) using the criteria described under subsection (a)(4)(D)(i)(II) of such section 804.

(f) IMPLEMENTATION OF SECTION 804.—

(1) INTERIM RULE.—The Secretary may promulgate an interim rule for implementing section 804 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a) of this section.

(2) NO NOTICE OF PROPOSED RULEMAKING.—The interim rule described under paragraph (1) may be developed and promulgated by the Secretary without providing general notice of proposed rulemaking.

(3) FINAL RULE.—Not later than 1 year after the date on which the Secretary promulgates an interim rule under paragraph (1), the Secretary shall, in accordance with procedures under section 553 of title 5, United States Code, promulgate a final rule for implementing such section 804, which may incorporate by reference provisions of the interim rule provided for under paragraph (1), to the extent that such provisions are not modified.

(g) CONSUMER EDUCATION.—The Secretary shall carry out activities that educate consumers—

(1) with regard to the availability of qualifying drugs for import for personal use from an exporter registered with and approved by the Food and Drug Administration under section 804 of the Federal Food, Drug, and Cosmetic Act, as added by this section, including information on how to verify whether an exporter is registered and approved by use of the Internet website of the Food and Drug Administration and the toll-free telephone number required by this title;

(2) that drugs that consumers attempt to import from an exporter that is not registered with and approved by the Food and Drug Administration can be seized by the United States Customs Service and destroyed, and that such drugs may be counterfeit, unapproved, unsafe, or ineffective;

(3) with regard to the suspension and termination of any registration of a registered importer or exporter under such section 804; and

(4) with regard to the availability at domestic retail pharmacies of qualifying drugs imported under such section 804 by domestic wholesalers and pharmacies registered with and approved by the Food and Drug Administration.

(h) EFFECT ON ADMINISTRATION PRACTICES.—Notwithstanding any provision of this title (and the amendments made by this title), the practices and policies of the Food and Drug Administration and Bureau of Customs and Border Protection, in effect on January 1, 2004, with respect to the importation of prescription drugs into the United States by an individual, on the person of such individual, for personal use, shall remain in effect.

(i) REPORT TO CONGRESS.—The Federal Trade Commission shall, on an annual basis, submit to Congress a report that describes any action taken during the period for which the report is being prepared to enforce the provisions of section 804(n) of the Federal Food, Drug, and Cosmetic Act (as added by this title), including any pending investigations or civil actions under such section.

SEC. 10005. DISPOSITION OF CERTAIN DRUGS DENIED ADMISSION INTO UNITED STATES.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.), as amended by section 10004, is further amended by adding at the end the following section:

"SEC. 805. DISPOSITION OF CERTAIN DRUGS DENIED ADMISSION.

''(a) IN GENERAL.—The Secretary of Homeland Security shall deliver to the Secretary a shipment of drugs that is imported or offered for import into the United States if—

''(1) the shipment has a declared value of less than $10,000; and

''(2)(A) the shipping container for such drugs does not bear the markings required under section 804(d)(2); or

''(B) the Secretary has requested delivery of such shipment of drugs.

''(b) NO BOND OR EXPORT.—Section 801(b) does not authorize the delivery to the owner or consignee of drugs delivered to the Secretary under subsection (a) pursuant to the execution of a bond, and such drugs may not be exported.

''(c) DESTRUCTION OF VIOLATIVE SHIPMENT.—The Secretary shall destroy a shipment of drugs delivered by the Secretary of Homeland Security to the Secretary under subsection (a) if—

''(1) in the case of drugs that are imported or offered for import from a registered exporter under section 804, the drugs are in violation of any standard described in section 804(g)(5); or

''(2) in the case of drugs that are not imported or offered for import from a registered exporter under section 804, the drugs are in violation of a standard referred to in section 801(a) or 801(d)(1).

''(d) CERTAIN PROCEDURES.—

''(1) IN GENERAL.—The delivery and destruction of drugs under this section may be carried out without notice to the importer, owner, or consignee of the drugs except as required by section 801(g) or section 804(i)(2). The issuance of receipts for the drugs, and recordkeeping activities regarding the drugs, may be carried out on a summary basis.

''(2) OBJECTIVE OF PROCEDURES.—Procedures promulgated under paragraph (1) shall be designed toward the objective of ensuring that, with respect to efficiently utilizing Federal resources available for carrying out this section, a substantial majority of shipments of drugs subject to described in subsection (c) are identified and destroyed.

''(e) EVIDENCE EXCEPTION.—Drugs may not be destroyed under subsection (c) to the extent that the Attorney General of the United States determines that the drugs should be preserved as evidence or potential evidence with respect to an offense against the United States.

''(f) RULE OF CONSTRUCTION.—This section may not be construed as having any legal effect on applicable law with respect to a shipment of drugs that is imported or offered for import into the United States and has a declared value equal to or greater than $10,000.''.

(b) PROCEDURES.—Procedures for carrying out section 805 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall be established not later than 90 days after the date of the enactment of this Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 90 days after the date of enactment of this Act.

SEC. 10006. WHOLESALE DISTRIBUTION OF DRUGS; STATEMENTS REGARDING PRIOR SALE, PURCHASE, OR TRADE.

(a) STRIKING OF EXEMPTIONS; APPLICABILITY TO REGISTERED EXPORTERS.—Section 503(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(e)) is amended—

(1) in paragraph (1)—

(A) by striking ''and who is not the manufacturer or an authorized distributor of record of such drug'';

(B) by striking ''to an authorized distributor of record or''; and

(C) by striking subparagraph (B) and inserting the following:

''(B) The fact that a drug subject to subsection (b) is exported from the United States does not with respect to such drug exempt any person that is engaged in the business of the wholesale distribution of the drug from providing the statement described in subparagraph (A) to the person that receives the drug pursuant to the export of the drug.

''(C)(i) The Secretary shall by regulation establish requirements that supersede subparagraph (A) (referred to in this subparagraph as 'alternative requirements') to identify the chain of custody of a drug subject to subsection (b) from the manufacturer of the drug throughout the wholesale distribution of the drug to a pharmacist who intends to sell the drug at retail if the Secretary determines that the alternative requirements, which may include standardized anti-counterfeiting or track-and-trace technologies, will identify such chain of custody or the identity of the discrete package of the drug

from which the drug is dispensed with equal or greater certainty to the requirements of subparagraph (A), and that the alternative requirements are economically and technically feasible.

''(ii) When the Secretary promulgates a final rule to establish such alternative requirements, the final rule in addition shall, with respect to the registration condition established in clause (i) of section 804(c)(3)(B), establish a condition equivalent to the alternative requirements, and such equivalent condition may be met in lieu of the registration condition established in such clause (i).'';

(2) in paragraph (2)(A), by adding at the end the following: ''The preceding sentence may not be construed as having any applicability with respect to a registered exporter under section 804.''; and

(3) in paragraph (3), by striking ''and subsection (d)—'' in the matter preceding subparagraph (A) and all that follows through ''the term 'wholesale distribution' means'' in subparagraph (B) and inserting the following: ''and subsection (d), the term 'wholesale distribution' means''.

(b) CONFORMING AMENDMENT.—Section 503(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(d)) is amended by adding at the end the following:

''(4) Each manufacturer of a drug subject to subsection (b) shall maintain at its corporate offices a current list of the authorized distributors of record of such drug.

''(5) For purposes of this subsection, the term 'authorized distributors of record' means those distributors with whom a manufacturer has established an ongoing relationship to distribute such manufacturer's products.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by paragraphs (1) and (3) of subsection (a) and by subsection (b) shall take effect on January 1, 2012.

(2) DRUGS IMPORTED BY REGISTERED IMPORTERS UNDER SECTION 804.—Notwithstanding paragraph (1), the amendments made by paragraphs (1) and (3) of subsection (a) and by subsection (b) shall take effect on the date that is 90 days after the date of enactment of this Act with respect to qualifying drugs imported under section 804 of the Federal Food, Drug, and Cosmetic Act, as added by section 10004.

(3) EFFECT WITH RESPECT TO REGISTERED EXPORTERS.—The amendment made by subsection (a)(2) shall take effect on the date that is 90 days after the date of enactment of this Act.

(4) ALTERNATIVE REQUIREMENTS.—The Secretary shall issue regulations to establish the alternative requirements, referred to in the amendment made by subsection (a)(1), that take effect not later than January 1, 2012.

(5) INTERMEDIATE REQUIREMENTS.—The Secretary shall by regulation require the use of standardized anti-counterfeiting or track-and-trace technologies on prescription drugs at the case and pallet level effective not later than 1 year after the date of enactment of this Act.

(6) ADDITIONAL REQUIREMENTS.—

(A) IN GENERAL.—Notwithstanding any other provision of this section, the Secretary shall, not later than 18 months after the date of enactment of this Act, require that the packaging of any prescription drug incorporates—

(i) a standardized numerical identifier unique to each package of such drug, applied at the point of manufacturing and repackaging (in which case the numerical identifier shall be linked to the numerical identifier applied at the point of manufacturing); and

(ii)(I) overt optically variable counterfeit-resistant technologies that—

(aa) are visible to the naked eye, providing for visual identification of product authenticity without the need for readers, microscopes, lighting devices, or scanners;

(bb) are similar to that used by the Bureau of Engraving and Printing to secure United States currency;

(cc) are manufactured and distributed in a highly secure, tightly controlled environment; and

(dd) incorporate additional layers of nonvisible convert security features up to and including forensic capability, as described in subparagraph (B); or

(II) technologies that have a function of security comparable to that described in subclause (I), as determined by the Secretary.

(B) STANDARDS FOR PACKAGING.—For the purpose of making it more difficult to counterfeit the packaging of drugs subject to this paragraph, the manufacturers of such drugs shall incorporate the technologies described in subparagraph (A) into at least 1 additional element of the physical packaging of the drugs, including blister packs, shrink wrap, package labels, package seals, bottles, and boxes.

SEC. 10007. INTERNET SALES OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503B the following:

''SEC. 503C. INTERNET SALES OF PRESCRIPTION DRUGS.

''(a) REQUIREMENTS REGARDING INFORMATION ON INTERNET SITE.—

''(1) IN GENERAL.—A person may not dispense a prescription drug pursuant to a sale of the drug by such person if—

''(A) the purchaser of the drug submitted the purchase order for the drug, or conducted any other part of the sales transaction for the drug, through an Internet site;

''(B) the person dispenses the drug to the purchaser by mailing or shipping the drug to the purchaser; and

''(C) such site, or any other Internet site used by such person for purposes of sales of a prescription drug, fails to meet each of the requirements specified in paragraph (2), other than a site or pages on a site that—

''(i) are not intended to be accessed by purchasers or prospective purchasers; or

''(ii) provide an Internet information location tool within the meaning of section 231(e)(5) of the Communications Act of 1934 (47 U.S.C. 231(e)(5)).

''(2) REQUIREMENTS.—With respect to an Internet site, the requirements referred to in subparagraph (C) of paragraph (1) for a person to whom such paragraph applies are as follows:

''(A) Each page of the site shall include either the following information or a link to a page that provides the following information:

''(i) The name of such person.

''(ii) Each State in which the person is authorized by law to dispense prescription drugs.

''(iii) The address and telephone number of each place of business of the person with respect to sales of prescription drugs through the Internet, other than a place of business that does not mail or ship prescription drugs to purchasers.

''(iv) The name of each individual who serves as a pharmacist for prescription drugs that are mailed or shipped pursuant to the site, and each State in which the individual is authorized by law to dispense prescription drugs.

''(v) If the person provides for medical consultations through the site for purposes of providing prescriptions, the name of each individual who provides such consultations; each State in which the individual is licensed or otherwise authorized by law to provide such consultations or practice medicine; and the type or types of health professions for which the individual holds such licenses or other authorizations.

''(B) A link to which paragraph (1) applies shall be displayed in a clear and prominent place and manner, and shall include in the caption for the link the words 'licensing and contact information'.

''(b) INTERNET SALES WITHOUT APPROPRIATE MEDICAL RELATIONSHIPS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a person may not dispense a prescription drug, or sell such a drug, if—

''(A) for purposes of such dispensing or sale, the purchaser communicated with the person through the Internet;

''(B) the patient for whom the drug was dispensed or purchased did not, when such communications began, have a prescription for the drug that is valid in the United States;

''(C) pursuant to such communications, the person provided for the involvement of a practitioner, or an individual represented by the person as a practitioner, and the practitioner or such individual issued a prescription for the drug that was purchased;

''(D) the person knew, or had reason to know, that the practitioner or the individual referred to in subparagraph (C) did not, when issuing the prescription, have a qualifying medical relationship with the patient; and

''(E) the person received payment for the dispensing or sale of the drug.

For purposes of subparagraph (E), payment is received if money or other valuable consideration is received.

''(2) EXCEPTIONS.—Paragraph (1) does not apply to—

''(A) the dispensing or selling of a prescription drug pursuant to telemedicine practices sponsored by—

''(i) a hospital that has in effect a provider agreement under title XVIII of the Social Security Act (relating to the Medicare program); or

''(ii) a group practice that has not fewer than 100 physicians who have in effect provider agreements under such title; or

''(B) the dispensing or selling of a prescription drug pursuant to practices that promote the public health, as determined by the Secretary by regulation.

''(3) QUALIFYING MEDICAL RELATIONSHIP.—

''(A) IN GENERAL.—With respect to issuing a prescription for a drug for a patient, a practitioner has a qualifying medical relationship with the patient for purposes of this section if—

''(i) at least one in-person medical evaluation of the patient has been conducted by the practitioner; or

''(ii) the practitioner conducts a medical evaluation of the patient as a covering practitioner.

''(B) IN-PERSON MEDICAL EVALUATION.—A medical evaluation by a practitioner is an in-person medical evaluation for purposes of this section if the practitioner is in the physical presence of the patient as part of conducting the evaluation, without regard to whether portions of the evaluation are conducted by other health professionals.

''(C) COVERING PRACTITIONER.—With respect to a patient, a practitioner is a covering practitioner for purposes of this section if the practitioner conducts a medical evaluation of the patient at the request of a practitioner who has conducted at least one in-person medical evaluation of the patient and is temporarily unavailable to conduct the evaluation of the patient. A practitioner is a covering practitioner without regard to whether the practitioner has conducted any in-person medical evaluation of the patient involved.

''(4) RULES OF CONSTRUCTION.—

''(A) INDIVIDUALS REPRESENTED AS PRACTITIONERS.—A person who is not a practitioner (as defined in subsection (e)(1)) lacks legal capacity under this section to have a qualifying medical relationship with any patient.

''(B) STANDARD PRACTICE OF PHARMACY.—Paragraph (1) may not be construed as prohibiting any conduct that is a standard practice in the practice of pharmacy.

''(C) APPLICABILITY OF REQUIREMENTS.—Paragraph (3) may not be construed as having any applicability beyond this section, and does not affect any State law, or interpretation of State law, concerning the practice of medicine.

''(c) ACTIONS BY STATES.—

''(1) IN GENERAL.—Whenever an attorney general of any State has reason to believe that the interests of the residents of that State have been or are being threatened or adversely affected because any person has engaged or is engaging in a pattern or practice that violates section 301(l), the State may bring a civil action on behalf of its residents in an appropriate district court of the United States to enjoin such practice, to enforce compliance with such section (including a nationwide injunction), to obtain damages, restitution, or other compensation on behalf of residents of such State, to obtain reasonable attorneys fees and costs if the State prevails in the civil action, or to obtain such further and other relief as the court may deem appropriate.

''(2) NOTICE.—The State shall serve prior written notice of any civil action under paragraph (1) or (5)(B) upon the Secretary and provide the Secretary with a copy of its complaint, except that if it is not feasible for the State to provide such prior notice, the State shall serve such notice immediately upon instituting such action. Upon receiving a notice respecting a civil action, the Secretary shall have the right—

''(A) to intervene in such action;

''(B) upon so intervening, to be heard on all matters arising therein; and

''(C) to file petitions for appeal.

''(3) CONSTRUCTION.—For purposes of bringing any civil action under paragraph (1), nothing in this chapter shall prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of such State to conduct investigations or to administer oaths or affirmations or to compel the attendance of witnesses or the production of documentary and other evidence.

''(4) VENUE; SERVICE OF PROCESS.—Any civil action brought under paragraph (1) in a district court of the United States may be brought in the district in which the defendant is found, is an inhabitant, or transacts business or wherever venue is proper under section 1391 of title 28, United States Code. Process in such an action may be served in any district in which the defendant is an inhabitant or in which the defendant may be found.

''(5) ACTIONS BY OTHER STATE OFFICIALS.—

''(A) Nothing contained in this section shall prohibit an authorized State official from proceeding in State court on the basis of an alleged violation of any civil or criminal statute of such State.

''(B) In addition to actions brought by an attorney general of a State under paragraph (1), such an action may be brought by officers of such State who are authorized by the State to bring actions in such State on behalf of its residents.

''(d) EFFECT OF SECTION.—This section shall not apply to a person that is a registered exporter under section 804.

''(e) GENERAL DEFINITIONS.—For purposes of this section:

''(1) The term 'practitioner' means a practitioner referred to in section 503(b)(1) with respect to issuing a written or oral prescription.

''(2) The term 'prescription drug' means a drug that is described in section 503(b)(1).

''(3) The term 'qualifying medical relationship', with respect to a practitioner and a patient, has the meaning indicated for such term in subsection (b).

''(f) INTERNET-RELATED DEFINITIONS.—

''(1) IN GENERAL.—For purposes of this section:

''(A) The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected world-wide network of networks that employ the transmission control protocol/internet protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio.

''(B) The term 'link', with respect to the Internet, means one or more letters, words, numbers, symbols, or graphic items that appear on a page of an Internet site for the purpose of serving, when activated, as a method for executing an electronic command—

''(i) to move from viewing one portion of a page on such site to another portion of the page;

''(ii) to move from viewing one page on such site to another page on such site; or

''(iii) to move from viewing a page on one Internet site to a page on another Internet site.

''(C) The term 'page', with respect to the Internet, means a document or other file accessed at an Internet site.

''(D)(i) The terms 'site' and 'address', with respect to the Internet, mean a specific location on the Internet that is determined by Internet Protocol numbers. Such term includes the domain name, if any.

''(ii) The term 'domain name' means a method of representing an Internet address without direct reference to the Internet Protocol numbers for the address, including methods that use designations such as '.com', '.edu', '.gov', '.net', or '.org'.

''(iii) The term 'Internet Protocol numbers' includes any successor protocol for determining a specific location on the Internet.

''(2) AUTHORITY OF SECRETARY.—The Secretary may by regulation modify any definition under paragraph (1) to take into account changes in technology.

''(g) INTERACTIVE COMPUTER SERVICE; ADVERTISING.—No provider of an interactive computer service, as defined in section 230(f)(2) of the Communications Act of 1934 (47 U.S.C. 230(f)(2)), or of advertising services shall be liable under this section for dispensing or selling prescription drugs in violation of this section on account of another person's selling or dispensing such drugs, provided that the provider of the interactive computer service or of advertising services does not own or exercise corporate control over such person.

''(h) NO EFFECT ON OTHER REQUIREMENTS; COORDINATION.—The requirements of this section are in addition to, and do not supersede, any requirements under the Controlled Substances Act or the Controlled Substances Import and Export Act (or any regulation promulgated under either such Act) regarding Internet pharmacies and controlled substances. In promulgating regulations to carry out this section, the Secretary shall coordinate with the Attorney General to ensure that such regulations do not duplicate or conflict with the requirements described in the previous sentence, and that such regulations and requirements coordinate to the extent practicable.''.

(b) INCLUSION AS PROHIBITED ACT.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by inserting after paragraph (k) the following:

''(l) The dispensing or selling of a prescription drug in violation of section 503C.''.

(c) INTERNET SALES OF PRESCRIPTION DRUGS; CONSIDERATION BY SECRETARY OF PRACTICES AND PROCEDURES FOR CERTIFICATION OF LEGITIMATE BUSINESSES.—In carrying out section 503C of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall take into consideration the practices and procedures of public or private entities that certify that businesses selling prescription drugs through Internet sites are legitimate businesses, including practices and procedures regarding disclosure formats and verification programs.

(d) REPORTS REGARDING INTERNET-RELATED VIOLATIONS OF FEDERAL AND STATE LAWS ON DISPENSING OF DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, pursuant to the submission of an application meeting the criteria of the Secretary, make an award of a grant or contract to the National Clearinghouse on Internet Prescribing (operated by the Federation of State Medical Boards) for the purpose of—

(A) identifying Internet sites that appear to be in violation of Federal or State laws concerning the dispensing of drugs;

(B) reporting such sites to State medical licensing boards and State pharmacy licensing boards, and to the Attorney General and the Secretary, for further investigation; and

(C) submitting, for each fiscal year for which the award under this subsection is made, a report to the Secretary describing investigations undertaken with respect to violations described in subparagraph (A).

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there is authorized to be appropriated $100,000 for each of the first 3 fiscal years in which this section is in effect.

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect 90 days after the date of enactment of this Act, without regard to whether a final rule to implement such amendments has been promulgated by the Secretary of Health and Human Services under section 701(a) of the Federal Food, Drug, and Cosmetic Act. The preceding sentence may not be construed as affecting the authority of such Secretary to promulgate such a final rule.

SEC. 10008. PROHIBITING PAYMENTS TO UNREGISTERED FOREIGN PHARMACIES.

(a) IN GENERAL.—Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) RESTRICTED TRANSACTIONS.—

''(1) IN GENERAL.—The introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system is prohibited.

''(2) PAYMENT SYSTEM.—

''(A) IN GENERAL.—The term 'payment system' means a system used by a person described in subparagraph (B) to effect a credit transaction, electronic fund transfer, or money transmitting service that may be used in connection with, or to facilitate, a restricted transaction, and includes—

''(i) a credit card system;

''(ii) an international, national, regional, or local network used to effect a credit transaction, an electronic fund transfer, or a money transmitting service; and

''(iii) any other system that is centrally managed and is primarily engaged in the

transmission and settlement of credit transactions, electronic fund transfers, or money transmitting services.

''(B) PERSONS DESCRIBED.—A person referred to in subparagraph (A) is—

''(i) a creditor;

''(ii) a credit card issuer;

''(iii) a financial institution;

''(iv) an operator of a terminal at which an electronic fund transfer may be initiated;

''(v) a money transmitting business; or

''(vi) a participant in an international, national, regional, or local network used to effect a credit transaction, electronic fund transfer, or money transmitting service.

''(3) RESTRICTED TRANSACTION.—The term 'restricted transaction' means a transaction or transmittal, on behalf of an individual who places an unlawful drug importation request to any person engaged in the operation of an unregistered foreign pharmacy, of—

''(A) credit, or the proceeds of credit, extended to or on behalf of the individual for the purpose of the unlawful drug importation request (including credit extended through the use of a credit card);

''(B) an electronic fund transfer or funds transmitted by or through a money transmitting business, or the proceeds of an electronic fund transfer or money transmitting service, from or on behalf of the individual for the purpose of the unlawful drug importation request;

''(C) a check, draft, or similar instrument which is drawn by or on behalf of the individual for the purpose of the unlawful drug importation request and is drawn on or payable at or through any financial institution; or

''(D) the proceeds of any other form of financial transaction (identified by the Board by regulation) that involves a financial institution as a payor or financial intermediary on behalf of or for the benefit of the individual for the purpose of the unlawful drug importation request.

''(4) UNLAWFUL DRUG IMPORTATION REQUEST.—The term 'unlawful drug importation request' means the request, or transmittal of a request, made to an unregistered foreign pharmacy for a prescription drug by mail (including a private carrier), facsimile, phone, or electronic mail, or by a means that involves the use, in whole or in part, of the Internet.

''(5) UNREGISTERED FOREIGN PHARMACY.—The term 'unregistered foreign pharmacy' means a person in a country other than the United States that is not a registered exporter under section 804.

''(6) OTHER DEFINITIONS.—

''(A) CREDIT; CREDITOR; CREDIT CARD.—The terms 'credit', 'creditor', and 'credit card' have the meanings given the terms in section 103 of the Truth in Lending Act (15 U.S.C. 1602).

''(B) ACCESS DEVICE; ELECTRONIC FUND TRANSFER.—The terms 'access device' and 'electronic fund transfer'—

''(i) have the meaning given the term in section 903 of the Electronic Fund Transfer Act (15 U.S.C. 1693a); and

''(ii) the term 'electronic fund transfer' also includes any fund transfer covered under Article 4A of the Uniform Commercial Code, as in effect in any State.

''(C) FINANCIAL INSTITUTION.—The term 'financial institution'—

''(i) has the meaning given the term in section 903 of the Electronic Transfer Fund Act (15 U.S.C. 1693a); and

''(ii) includes a financial institution (as defined in section 509 of the Gramm-Leach-Bliley Act (15 U.S.C. 6809)).

''(D) MONEY TRANSMITTING BUSINESS; MONEY TRANSMITTING SERVICE.—The terms 'money transmitting business' and 'money transmitting service' have the meaning given the terms in section 5330(d) of title 31, United States Code.

''(E) BOARD.—The term 'Board' means the Board of Governors of the Federal Reserve System.

''(7) POLICIES AND PROCEDURES REQUIRED TO PREVENT RESTRICTED TRANSACTIONS.—

''(A) REGULATIONS.—The Board shall promulgate regulations requiring—

''(i) an operator of a credit card system;

''(ii) an operator of an international, national, regional, or local network used to effect a credit transaction, an electronic fund transfer, or a money transmitting service;

''(iii) an operator of any other payment system that is centrally managed and is primarily engaged in the transmission and settlement of credit transactions, electronic transfers or money transmitting services where at least one party to the transaction or transfer is an individual; and

''(iv) any other person described in paragraph (2)(B) and specified by the Board in such regulations,

to establish policies and procedures that are reasonably designed to prevent the introduction of a restricted transaction into a payment system or the completion of a restricted transaction using a payment system

''(B) REQUIREMENTS FOR POLICIES AND PROCEDURES.—In promulgating regulations under subparagraph (A), the Board shall—

''(i) identify types of policies and procedures, including nonexclusive examples, that shall be considered to be reasonably designed to prevent the introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system; and

''(ii) to the extent practicable, permit any payment system, or person described in paragraph (2)(B), as applicable, to choose among alternative means of preventing the introduction or completion of restricted transactions.

''(C) NO LIABILITY FOR BLOCKING OR REFUSING TO HONOR RESTRICTED TRANSACTION.—

''(i) IN GENERAL.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, and any participant in such payment system that prevents or otherwise refuses to honor transactions in an effort to implement the policies and procedures required under this subsection or to otherwise comply with this subsection shall not be liable to any party for such action.

''(ii) COMPLIANCE.—A person described in paragraph (2)(B) meets the requirements of this subsection if the person relies on and complies with the policies and procedures of a payment system of which the person is a member or in which the person is a participant, and such policies and procedures of the payment system comply with the requirements of the regulations promulgated under subparagraph (A).

''(D) ENFORCEMENT.—

''(i) IN GENERAL.—This subsection, and the regulations promulgated under this subsection, shall be enforced exclusively by the Federal functional regulators and the Federal Trade Commission under applicable law in the manner provided in section 505(a) of the Gramm-Leach-Bliley Act (15 U.S.C. 6805(a)).

''(ii) FACTORS TO BE CONSIDERED.—In considering any enforcement action under this subsection against a payment system or person described in paragraph (2)(B), the Federal functional regulators and the Federal Trade Commission shall consider the following factors:

''(I) The extent to which the payment system or person knowingly permits restricted transactions.

''(II) The history of the payment system or person in connection with permitting restricted transactions.

''(III) The extent to which the payment system or person has established and is maintaining policies and procedures in compliance with regulations prescribed under this subsection.

''(8) TRANSACTIONS PERMITTED.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, is authorized to engage in transactions with foreign pharmacies in connection with investigating violations or potential violations of any rule or requirement adopted by the payment system or person in connection with complying with paragraph (7). A payment system, or such a person, and its agents and employees shall not be found to be in violation of, or liable under, any Federal, State or other law by virtue of engaging in any such transaction.

''(9) RELATION TO STATE LAWS.—No requirement, prohibition, or liability may be imposed on a payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, under the laws of any state with respect to any payment transaction by an individual because the payment transaction involves a payment to a foreign pharmacy.

''(10) TIMING OF REQUIREMENTS.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, must adopt policies and procedures reasonably designed to comply with any regulations required under paragraph (7) within 60 days after such regulations are issued in final form.

''(11) COMPLIANCE.—A payment system, and any person described in paragraph (2)(B), shall not be deemed to be in violation of paragraph (1)—

''(A)(i) if an alleged violation of paragraph (1) occurs prior to the mandatory compliance date of the regulations issued under paragraph (7); and

''(ii) such entity has adopted or relied on policies and procedures that are reasonably designed to prevent the introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system; or

''(B)(i) if an alleged violation of paragraph (1) occurs after the mandatory compliance date of such regulations; and

''(ii) such entity is in compliance with such regulations.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the day that is 90 days after the date of enactment of this Act.

(c) IMPLEMENTATION.—The Board of Governors of the Federal Reserve System shall promulgate regulations as required by subsection (h)(7) of section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333), as added by subsection (a), not later than 90 days after the date of enactment of this Act.

SEC. 10009. IMPORTATION EXEMPTION UNDER CONTROLLED SUBSTANCES IMPORT AND EXPORT ACT.

Section 1006(a)(2) of the Controlled Substances Import and Export Act (21 U.S.C. 956(a)(2)) is amended by striking ''not import the controlled substance into the United States in an amount that exceeds 50 dosage units of the controlled substance.'' and inserting ''import into the United States not more than 10 dosage units combined of all such controlled substances.''.

SEC. 10010. SEVERABILITY.

If any provision of this title, an amendment by this title, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this title, the amendments

made by this title, and the application of the provisions of such to any person or circumstance shall not affected thereby.

SA 2794. Mr. LEAHY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

SEC. 4403. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) IN GENERAL.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended—

(1) in subsection (g), by striking paragraph (4) and inserting the following:

''(4) An entity described in this paragraph is—

''(A) a public or non-profit private entity receiving Federal funds under section 330; or

''(B) a free clinic defined under subsection (o)(3)(A).''; and

(2) in subsection (o)(6)(A), by inserting ''and officers, governing board members, employees, and contractors of free clinics'' after ''free clinic health professionals''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SA 2795. Mr. LEAHY (for himself, Mr. REID, Mr. KERRY, Mr. ROCKEFELLER, Mr. LIEBERMAN, Mrs. FEINSTEIN, Mr. FEINGOLD, Mr. WYDEN, Mr. SCHUMER, Ms. CANTWELL, Mr. LAUTENBERG, Mrs. MCCASKILL, Mr. WHITEHOUSE, Mr. BURRIS, Mr. KAUFMAN, Mr. BENNETT, and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table, as follows:

On page 377, after line 14, insert the following:

SEC. 1561A. HEALTH INSURANCE INDUSTRY ANTITRUST ENFORCEMENT ACT OF 2009.

(a) SHORT TITLE.—This section may be cited as the ''Health Insurance Industry Antitrust Enforcement Act of 2009''.

(b) PURPOSE.—It is the purpose of this section to ensure that health insurance issuers and medical malpractice insurance issuers cannot engage in price fixing, bid rigging, or market allocations to the detriment of competition and consumers.

(c) PROHIBITION OF ANTI-COMPETITIVE ACTIVITIES.—Notwithstanding any other provision of law, nothing in the Act of March 9, 1945 (15 U.S.C. 1011 et seq., commonly known as the ''McCarran-Ferguson Act''), shall be construed to permit health insurance issuers (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) or issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging, or market allocations in connection with the conduct of the business of providing health insurance coverage (as defined in such section) or coverage for medical malpractice claims or actions.

(d) APPLICATION TO ACTIVITIES OF STATE COMMISSIONS OF INSURANCE AND OTHER STATE INSURANCE REGULATORY BODIES.—Nothing in this section shall apply to the information gathering and rate setting activities of any State commission of insurance, or any other State regulatory entity with authority to set insurance rates.

SA 2796. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights; as follows:

Strike all after the resolving clause and insert the following:

That the Senate—

(1) condemns the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights;

(2) calls on the Government of Iran to immediately release the seven leaders and all other prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi; and

(3) calls on the President and Secretary of State, in cooperation with responsible nations, to immediately condemn the Government of Iran's continued violation of human rights and demand the immediate release of prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi.

SA 2797. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights; as follows:

Strike the preamble and insert the following:

Whereas, in 1982, 1984, 1988, 1990, 1992, 1994, 1996, 2000, 2006, and 2008, Congress declared that it deplored the religious persecution by the Government of Iran of the Baha'i community and would hold the Government of Iran responsible for upholding the rights of all Iranian nationals, including members of the Baha'i faith;

Whereas, in November 2007, the Iranian Ministry of Information in Shiraz jailed Baha'is Ms. Raha Sabet, age 33, Mr. Sasan Taqva, age 32, and Ms. Haleh Roohi, age 29, for ostensibly ''indirectly teaching the Baha'i Faith'' and ''engaging in anti-government propaganda'' while educating underprivileged children and gave them 4-year prison terms, which they are serving;

Whereas Ms. Sabet, Mr. Taqva, and Ms. Roohi were targeted solely on the basis of their religion;

Whereas, on January 23, 2008, the Department of State released a statement urging the Government of Iran to release all individuals held without due process and a fair trial, including the 3 young Baha'is being held in an Iranian Ministry of Intelligence detention center in Shiraz;

Whereas, in March and May of 2008, Iranian intelligence officials in Mashhad and Tehran arrested and imprisoned Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, and Mr. Vahid Tizfahm, the members of the coordinating group for the Baha'i community in Iran;

Whereas these seven leaders have been imprisoned for well over a year and are yet to stand trial, the trial having been delayed multiple times;

Whereas official Iranian media has announced that they will face charges of ''espionage for Israel, insulting religious sanctities and propaganda against the Islamic Republic'';

Whereas these seven Baha'i leaders were targeted solely on the basis of their religion; and

Whereas the Government of Iran is party to the International Covenants on Human Rights: Now, therefore, be it

---

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Energy. The hearing will be held on Tuesday, December 8, 2009, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills:

H.R. 957, Green Energy Education Act of 2009;

H.R. 2729, To authorize the designation of National Environmental Research Parks by the Secretary of Energy, and for other purposes;

H.R. 3165, Wind Energy Research and Development Act of 2009;

H.R. 3246, Advanced Vehicle Technology Act of 2009; H.R. 3585, Solar Technology Roadmap Act;

S. 737, A bill to amend the Energy Independence and Security Act of 2007 to authorize the Secretary of Energy to conduct research, development, and demonstration to make biofuels more compatible with small non-road engines, and for other purposes;

S. 1617, To require the Secretary of Commerce to establish a program for the award of grants to States to establish revolving loan funds for small and medium-sized manufacturers to improve energy efficiency and produce clean energy technology, and for other purposes;

S. 2744, A bill to amend the Energy Policy Act of 2005 to expand the authority for awarding technology prizes by the Secretary of Energy to include a financial award for separation of carbon dioxide from dilute sources; and

S. 2773, A bill to require the Secretary of Energy to carry out a program to support the research, demonstration, and development of commercial applications for offshore wind energy, and for other purposes.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie Calabro@energy.senate.gov.

For further information, please contact Jonathan Epstein or Rosemarie Calabro.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON FOREIGN RELATIONS

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 1, 2009, at 10 a.m.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 1, 2009, at 2:30 p.m.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 1, 2009, at 12 p.m.

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

COMMITTEE ON THE JUDICIARY

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 1, 2009, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Judicial Nominations.''

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. LEAHY. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 1, 2009, at 2:30 p.m.

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

SUBCOMMITTEE ON AVIATION OPERATIONS, SAFETY, AND SECURITY

Mr. LEAHY. Mr. President, I ask unanimous consent that the Subcommittee on Aviation Operations, Safety, and Security of the Committee on Commerce, Science, and Transportation be authorized to hold a meeting during the session of the Senate on December 1, 2009, at 10:15 a.m. in room 253 of the Russell Senate Office Building.

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

PRIVILEGES OF THE FLOOR

Mrs. SHAHEEN. Mr. President, I ask unanimous consent that Manny Jimenez, a fellow in my office, be granted floor privileges for the duration of the consideration of H.R. 3590.

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

CONDEMNING THE PERSECUTION OF THE BAHA'I MINORITY IN IRAN

Mr. DURBIN. I ask unanimous consent that the Foreign Relations Committee be discharged from further consideration of S. Res. 71 and the Senate proceed to its immediate consideration.

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

The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 71) condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent that a Wyden amendment to the resolution, which is at the desk, be agreed to; the resolution, as amended, be agreed to; that a Wyden amendment to the preamble, which is at the desk, be agreed to; the preamble, as amended, be agreed to; the motions to reconsider be laid upon the table, with no intervening action or debate; and any statements related to the resolution be printed in the RECORD.

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

The amendment (No. 2796) was agreed to, as follows:

(Purpose: In the nature of a substitute)

Strike all after the resolving clause and insert the following:

That the Senate—

(1) condemns the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights;

(2) calls on the Government of Iran to immediately release the seven leaders and all other prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi; and

(3) calls on the President and Secretary of State, in cooperation with responsible nations, to immediately condemn the Government of Iran's continued violation of human rights and demand the immediate release of prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi.

The amendment (No. 2797) was agreed to, as follows:

Strike the preamble and insert the following:

Whereas, in 1982, 1984, 1988, 1990, 1992, 1994, 1996, 2000, 2006, and 2008, Congress declared that it deplored the religious persecution by the Government of Iran of the Baha'i community and would hold the Government of Iran responsible for upholding the rights of all Iranian nationals, including members of the Baha'i faith;

Whereas, in November 2007, the Iranian Ministry of Information in Shiraz jailed Baha'is Ms. Raha Sabet, age 33, Mr. Sasan Taqva, age 32, and Ms. Haleh Roohi, age 29, for ostensibly ''indirectly teaching the Baha'i Faith'' and ''engaging in anti-government propaganda'' while educating underprivileged children and gave them 4-year prison terms, which they are serving;

Whereas Ms. Sabet, Mr. Taqva, and Ms. Roohi were targeted solely on the basis of their religion;

Whereas, on January 23, 2008, the Department of State released a statement urging the Government of Iran to release all individuals held without due process and a fair trial, including the 3 young Baha'is being held in an Iranian Ministry of Intelligence detention center in Shiraz;

Whereas, in March and May of 2008, Iranian intelligence officials in Mashhad and Tehran arrested and imprisoned Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, and Mr. Vahid Tizfahm, the members of the coordinating group for the Baha'i community in Iran;

Whereas these seven leaders have been imprisoned for well over a year and are yet to stand trial, the trial having been delayed multiple times;

Whereas official Iranian media has announced that they will face charges of ''espionage for Israel, insulting religious sanctities and propaganda against the Islamic Republic'';

Whereas these seven Baha'i leaders were targeted solely on the basis of their religion; and

Whereas the Government of Iran is party to the International Covenants on Human Rights: Now, therefore, be it

The resolution (S. Res. 71), as amended, was agreed to.

The preamble, as amended, was agreed to.

The resolution, as amended, with its preamble, as amended, was agreed to, as follows:

S. RES. 71

Whereas in 1982, 1984, 1988, 1990, 1992, 1994, 1996, 2000, 2006, and 2008, Congress declared that it deplored the religious persecution by the Government of Iran of the Baha'i community and would hold the Government of Iran responsible for upholding the rights of all Iranian nationals, including members of the Baha'i faith;

Whereas in November 2007, the Iranian Ministry of Information in Shiraz jailed Baha'is Ms. Raha Sabet, age 33, Mr. Sasan Taqva, age 32, and Ms. Haleh Roohi, age 29, for ostensibly ''indirectly teaching the Baha'i Faith'' and ''engaging in anti-government propaganda'' while educating underprivileged children and gave them 4-year prison terms, which they are serving;

Whereas Ms. Sabet, Mr. Taqva, and Ms. Roohi were targeted solely on the basis of their religion;

Whereas on January 23, 2008, the Department of State released a statement urging the Government of Iran to release all individuals held without due process and a fair trial, including the 3 young Baha'is being held in an Iranian Ministry of Intelligence detention center in Shiraz;

Whereas in March and May of 2008, Iranian intelligence officials in Mashhad and Tehran arrested and imprisoned Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, and Mr. Vahid Tizfahm, the members of the coordinating group for the Baha'i community in Iran;

Whereas these seven leaders have been imprisoned for well over a year and are yet to stand trial, the trial having been delayed multiple times;

Whereas official Iranian media has announced that they will face charges of ''espionage for Israel, insulting religious sanctities and propaganda against the Islamic Republic'';

Whereas these seven Baha'i leaders were targeted solely on the basis of their religion; and

Whereas the Government of Iran is party to the International Covenants on Human Rights: Now, therefore, be it

Resolved, That the Senate—

(1) condemns the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights;

(2) calls on the Government of Iran to immediately release the seven leaders and all other prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi; and

(3) calls on the President and Secretary of State, in cooperation with responsible nations, to immediately condemn the Government of Iran's continued violation of human rights and demand the immediate release of prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi.

WREATHS ACROSS AMERICA DAY

Mr. DURBIN. I ask unanimous consent that the Judiciary Committee be discharged from further consideration of and the Senate now proceed to S. Res. 358.

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

The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 358) designating December 12, 2009, as ''Wreaths Across America Day.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table.

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

The resolution (S. Res. 358) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 358

Whereas 18 years ago, the Wreaths Across America project began an annual tradition, during the month of December, of donating, transporting, and placing Maine balsam fir holiday wreaths on the graves of the fallen heroes buried at Arlington National Cemetery;

Whereas since that tradition began, through the hard work and generosity of the individuals involved in the Wreaths Across America project, hundreds of thousands of wreaths have been sent to national cemeteries and veterans memorials in every State and to locations overseas;

Whereas in 2008, wreaths were sent to 372 locations across the United States, as well as 24 sites overseas;

Whereas in December 2009, the Patriot Guard Riders, a motorcycle and motor vehicle group that is dedicated to patriotic events and includes more than 177,000 members nationwide, will continue their tradition of escorting a tractor-trailer filled with donated wreaths from Harrington, Maine, to Arlington National Cemetery;

Whereas thousands of individuals volunteer each December to escort and lay the wreaths;

Whereas, December 13, 2008, was previously designated by the Senate as ''Wreaths Across America Day''; and

Whereas the Wreaths Across America project will continue its proud legacy on December 12, 2009, bringing 15,000 wreaths to Arlington National Cemetery on that day: Now, therefore, be it

Resolved, That the Senate—

(1) designates December 12, 2009, as ''Wreaths Across America Day'';

(2) honors the Wreaths Across America project, the Patriot Guard Riders, and all of the volunteers and donors involved in this worthy tradition; and

(3) recognizes the sacrifices our veterans, servicemembers, and their families have made, and continue to make, for our great Nation.

50TH ANNIVERSARY OF THE ANTARCTIC TREATY

Mr. DURBIN. I ask unanimous consent the Senate proceed to the immediate consideration of S. Res. 365 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 365) recognizing the 50th anniversary of the signing of the Antarctic Treaty.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements related to the resolution be printed in the RECORD.

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

The resolution (S. Res. 365) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 365

Whereas the Antarctic Treaty was signed by 12 nations in Washington, DC, on December 1, 1959, ''with the interests of science and the progress of all mankind'';

Whereas the Antarctic Treaty was established to continue and develop international ''cooperation on the basis of freedom of scientific investigation in Antarctica as applied during the International Geophysical Year'';

Whereas the Antarctic Treaty came into force on June 23, 1961, after its unanimous ratification by the seven countries (Argentina, Australia, Chile, France, New Zealand, Norway, and the United Kingdom) with territorial claims in the region and five other countries (Belgium, Japan, South Africa, the Soviet Union, and the United States), which had collaborated in Antarctic research activities during the International Geophysical Year from July 1, 1957, through December 31, 1958;

Whereas the Antarctic Treaty now has 47 nations as signatories that together represent nearly 90 percent of humanity;

Whereas Article IV of the Antarctic Treaty states that ''no acts or activities taking place while the present Treaty is in force shall constitute a basis for asserting, supporting or denying a claim to territorial sovereignty in Antarctica'';

Whereas the 14 articles of the Antarctic Treaty have provided a lasting foundation for maintaining the region south of 60 degrees south latitude, nearly 10 percent of the Earth's surface, ''for peaceful purposes only'';

Whereas the Antarctic Treaty prohibits ''any measure of a military nature'';

Whereas the Antarctic Treaty has promoted international nuclear cooperation by prohibiting ''any nuclear explosions in Antarctica and the disposal there of radioactive waste material'';

Whereas the Antarctic Treaty provides a framework for the signatories to continue to meet ''for the purpose of exchanging information, consulting together on matters of common interest pertaining to Antarctica, and formulating and considering, and recommending to their Governments, measures in furtherance of the principles and objectives of the Treaty'';

Whereas common interests among the Antarctic Treaty nations facilitated the development and ratification of the Convention on the Conservation of Antarctic Marine Living Resources;

Whereas the international cooperation represented by the Antarctic Treaty offers humankind a precedent for the peaceful governance of international spaces;

Whereas in celebration of the 50th anniversary of the International Geophysical Year, the Antarctic Treaty Parties in their Edinburgh Declaration recognized the current International Polar Year for its contributions to science worldwide and to international cooperation; and

Whereas the International Polar Year program has endorsed the Antarctic Treaty Summit that will convene in Washington, DC, at the Smithsonian Institution on the 50th anniversary of the Antarctic Treaty: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes that the Antarctic Treaty has greatly contributed to science and science cooperation worldwide and successfully ensured the ''use of Antarctica for peaceful purposes only and the continuance of international harmony'' for the past half century; and

(2) encourages international and interdisciplinary collaboration in the Antarctic Treaty Summit to identify lessons from 50 years of international cooperation under the Antarctic Treaty that have legacy value for humankind.

ORDERS FOR WEDNESDAY, DECEMBER 2, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Wednesday, December 2; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, for debate only, with no amendments or motions in order; and that the time until 11:30 a.m. be equally divided, with alternating blocks of time, with the Republicans controlling the first 30 minutes, the majority controlling the second 30 minutes; further that the Senate recess from 11:30 a.m. to 12:30 p.m.

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

PROGRAM

Mr. DURBIN. Mr. President, rollcall votes are expected to occur throughout the day.

ORDER FOR ADJOURNMENT

Mr. DURBIN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senators ENZI and INHOFE.

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

The Senator from Wyoming.

HEALTH CARE REFORM

Mr. ENZI. Mr. President, after the speech by the Senator from Illinois, I feel compelled to make a few comments. One, he challenged us a little bit to do a bill in 2,000 pages or less. I am one of those people who do not think it can be done in less. I do not think there are nearly enough pages there to solve the biggest problem in the United States for every American.

People are not comprehending how big health care is. The bill we are doing will affect 100 percent of the people in America. I do not know if we have ever had a bill before that affected 100 percent of the people—100 percent of the people, 100 percent of the professions, 100 percent of the businesses. This is big. Everybody has a role in health care, and we are trying to condense it into 2,000 pages and make it seem a lot simpler than it is.

The reason our side has been saying you need to take this a step at a time and get it right is because that gives up some of the right. There are over 200 references in the 2,000 pages that say the Secretary of Health and Human Services will solve that particular problem; in other words, put in the details. We do not have nearly the details in there to actually run health care for America. Without the details, we do not know what the devil is, and that is the difficulty. So we really ought to break it down a step at a time.

One step I really think would calm America down is if we did Medicare as a separate step. That way we could assure seniors that Medicare was going to be for Medicare. Yes, there are savings in Medicare. Yes, Medicare is going broke. Use the savings for Medicare. It seems pretty simple to me.

One of the things they are complaining about is the doc fix we have. We are not paying doctors adequately to be willing to take Medicare patients. Of course, we are not paying them adequately to take Medicaid patients either. But we are not paying them right. It would cost about $250 billion to fix that.

Well, if we are talking about $464 billion worth of savings in Medicare, why not use that $250 billion to fix that problem so we have doctors. I do not care what kind of insurance you have, I do not care how much you pay for the insurance, if you cannot see a doctor, you really do not have insurance. That is what seniors are being faced with. That is what Medicaid people are being faced with.

Medicaid—well, that is another piece that ought to be maybe a step because 40 percent of the doctors will not take a Medicaid patient because they are not being paid adequately for it. If you are not paid adequately, you go broke. They are small businesses. They are affected by this bill in more than one way. They have to provide what we are saying is a government requirement for the minimum insurance they have, and they also have to live with whatever rules we put in there and whatever pay fixes we put in there.

On the government option, one of the things CBO said was, the only way that would ever bring down costs is if the government fixes prices for the doctors, for the hospitals. Well, we are kind of doing that in this bill for Medicare because we are telling nursing homes they are going to take a big cut. Nursing homes do not have a lot of margin, and if nursing homes go broke, people have to go a long ways, sometimes—in Wyoming, anyway, and Colorado, wherever we have rural populations—they may have to go a long way to see their loved one. They may not even be able to do it. So we have to keep those small nursing homes in business as well.

So we ought to do this in steps and get it right. That is one of the problems that the Group of 6 ran into. We were not given the time. We allocated about 13 different areas to go through. I think we made it through 5 completely and probably 3 fairly completely, and the rest we were just asking basic questions. With any business, it looks pretty easy until you scratch the surface a little bit, and when you scratch the surface, you find out that every job out there is fairly complicated. If you have never done it before, and you are trying to come up with 2,000 pages worth of laws to govern that, you are probably going to get it wrong.

That is what the doctors are telling us. That is what the other providers are telling us. This bill has it wrong, in a lot of places, enough places that it is going to cause a crisis in America if this bill passes the way it is.

We have never passed a major bill in this body with just one side voting for it. If that were to happen, the other side would take potshots at anything that turned out to be something that had not been comprehended when the bill was written. And there will be plenty of that in here.

But just as important, the American people will not have confidence in it. They do not have confidence in us now—either side. I think that is what the elections in Virginia and New Jersey said. That is what the tea parties are saying. They are saying: We don't trust any of you. Throw the whole bunch out. Start over.

Well, we need to stop and get their confidence. Just steamrolling from one side, even if they have the 60 votes, is not going to do that. I have been saying that since we started. It is something so important that we have to get it right, and we do not have it right in this bill because there are a whole bunch of things, over 200, where we said to the Secretary of Health and Human Services: You figure that one out. Well, that is going to be thousands of pages, and it is going to be done by an unelected bureaucrat. It is not going to be approved by this body.

We ought to take the responsibility for getting those things right. And we can. Yes, it takes time. Yes, we have a lot of things to do. But I am in agreement that health care is the most important thing we have to do. But we ought to take the time to get it right.

There are a lot of ideas out there that would—in fact, one of the things that always upsets me when they say: So where is the Republican version? Well, I have been working on this thing for about 4 years. I have been working on it, actually—health care—ever since I got on the committee over 13 years ago, but for the last 4 years pretty intensively.

Senator Kennedy and I sat down and worked out principles we wanted to have. The principles are still the principles we are talking about around here. We want to make sure people are covered in catastrophic situations. We want to make sure preexisting conditions are taken care of. We want to make sure they have portability when they go from one job to another. The list goes on and on. We reached agreement. He was busy working on the Higher Education Act because it was way past due for being reauthorized, so I was kind of released to go talk to everybody on health care. I worked that. I worked both sides of the aisle, finding out ideas they had, and boiled it down to a 10-step plan.

I did a tour with my 10-step plan to see what kind of problems there were with it and was really pleased with the reception. Yes, I learned some things that needed to be done differently than what I thought. But if you will check my Web site, there is a 10-step plan that is a bill that covers the things we have been promising people they would have. I would not suggest doing it in one package. I would suggest doing it in several steps, not necessarily 10 steps, which are what are in there. But it would bring down the cost of health care insurance. That is the biggest thing I hear from people out there: Bring down my cost.

Now, everybody has been real pleased with this CBO clarification that came out that said the costs were not going to rise. They did not say: Don't let them rise. They said: Bring them down. Bring them down. They said: We don't mind covering a whole bunch of other people, but don't increase my costs as a result. This bill increases their costs as a result.

There is a way to do it. There are four different bills on the Republican side. And then there is a really bipartisan bill that Senator WYDEN and Senator BENNETT worked out, and I think there are about 15 cosponsors on both sides of the aisle. Those are all ways that this could be solved. But they are not in the bill. Since Senator WYDEN was left out of that part of the process, I am not even sure it could be considered partisan because you have to include all from one party.

But, at any rate, there are alternates out there. When we did the health care bill, which took weeks of doing the amendments, because it is very hard to do something in an amendment process and get it right—it is easier in the committee than it is here on the floor—but in the committee, we put up one of those as an alternative. We only took one vote to vote the whole thing down. They only had to criticize about 3 parts of 20 to get enough enthusiasm against it to be able to win. All the votes were 13 to 10, pretty much.

So we said: Wait a minute. That is not a good idea for us. They should have to take a look at these germs of ideas that are in all these different sections. So we started putting them up one at a time. We still lost most of them 13 to 10. There were a couple of them that did finally pass.

But we need to get into a mode of working across the aisle, like Senator Kennedy and I did on so many bills. In fact, I think we set some records, probably, not just when I was chairman of the committee but when he was chairman of the committee. We were on our way to getting a bunch done.

Anyway, deficit reduction. I heard Senator DURBIN talk about deficit reduction, and if this bill reduces the deficit. You have to be honest. If you use phony accounting, you can show huge deficits being reduced. That means leaving out some things that aren't in the bill, but they are going to be costs we have to cover. For instance, the doc fix, $250 billion. It is not in there. They say we will fix it for 1 year and then we will hold them hostage again for another year so we can get them to join us on something else. That is not the right way to do business. We ought to fix the thing and if we have all of this extra money in Medicare, that would solve some problems for Medicare.

On Medicaid, we are about to dump a whole bunch more people onto the Medicaid system. It is nice we are going to be able to do that, but there are some other ways we can take care of those same people and make sure they have insurance, and they would have insurance that didn't have the same stigma as Medicaid. One of the stigmas I am talking about is the doctors not willing to take them. If you can't see a doctor, you don't have insurance. If we dump all of these people on a system that already won't take the patients, how many of them are going to be able to see a doctor? So we could eliminate that stigma. In fact, that is what we did in the SCHIP in Wyoming. We made a provision so that it could go through the private market. When they go through the private market—or when they don't go through the private market, a problem a kid has if their dad is working, they have insurance; if he is not working, they don't have insurance, or if it is mom. Under the Wyoming one, when they go through the private market they know they have it for a year. That is the way it ought to be. That is the way Medicaid should be. Of course, you have to sign up for it. Right now you don't have to sign up. You go to the hospital, you get your fix, and we pay for it, or the State pays their share. We are dumping a huge liability on the States, so it is a real problem.

The States are very concerned. Right now they are having budget problems almost across the entire United States. They are saying, so what are you going to dump on us? Well, our Gang of 6 asked that question and we got this overall CBO score on how much it was going to cost the States as a whole, but we didn't want to know how much it was going to cost as a whole. Every one of us has to answer to our State, so we asked for it to be broken down and they broke it down. It was kind of interesting. I had to call my Governor and explain to him how much he was going to have to come up with, even under the extra protection we were trying to build in for States. But the next day we got another breakdown. I said, so did CBO change their score? No, they didn't, but we manipulated the numbers a little bit differently. Well, they manipulated the numbers for Nevada and New York, and I think that is in the bill too. Their excuse for it was that Nevada and New York are particularly hard hit by the recession. Well, one of our complaints—and part of the phony accounting—is that this doesn't even go into effect for 4 more years, so how would we know that in 4 more years Nevada and New York would be the hardest hit? How do we know it won't be Wyoming and Colorado? So the formulas ought to be formulas that are going to work for everybody all of the time, not just for some of the leadership.

There are some flaws in here we need to take a look at and we need to clear up. I am not going to keep everybody much longer because I want to go hear the President speak too and I apologize for the time I have taken. But once in a while a speech gets me kind of concerned and I have to expound a little bit on it and I think the people of America need to know. Actually, I think the people of America have figured this out. I think that is why there were problems in August and I think that is why we are not going home on the weekends, because we don't want people to hear what the people at home are saying. I was home over the Thanksgiving weekend and I got an earful, and I like what I am doing. I don't think I like what is happening in the bill.

So with that, I yield the floor and thank the President, so the Senator from Oklahoma can speak.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. INHOFE. I thank the Senator from Wyoming.

Mr. President, the Senator from Wyoming made some references to the August recess and what happened during that time. I admire the Senator from Wyoming so much for the time he has spent on this issue. I, frankly, have not spent much time on this issue. We are kind of a product of our own committees in the Senate, but I do remember—and some people have forgotten—that during the August recess it was not just health care, it was also the cap-and-trade bill, because these are the bills that were passed right down party lines.

I have to disagree with the Senator from Wyoming in one respect and that is the people during the August recess were not upset with the Republicans. They were upset with the Democrats because the one bill in my State of Oklahoma is referred to as socialized medicine. They have a hard time believing that the government is going to be able to run anything better than what we have today. I know those in this Chamber who represent States up in the far north recognize that the hospitals, the Mayo Clinics, and some of those in the northern tier, are filled with people from Canada. They have come down to America because they can't get what they wanted in Canada. So I kind of looked around and the people in Oklahoma seem to understand that if it doesn't work in Denmark, if it doesn't work in the United Kingdom, and if it doesn't work in Canada, why would it work in the United States? The answer is clearly that it wouldn't.

The other issue that was prominent at that time was the issue of global warming. Six years ago I made the

statement that the notion that man-made gases, anthropogenic gases, CO_2, cause global warming is probably the greatest hoax ever perpetrated on the American people. I know that more and more people are using the hoax statement now. The reason that was such a big issue was it passed again in the House, right down party lines—this was the Waxman-Markey bill—that would have been a tax increase on the American people of well over $300 billion a year. That translates in my State of Oklahoma to about $3,000 a family, a tax-paying family. It is something we were not going to let happen and we still are not, but that is a reality. I wish to remind my fellow Senators: You may think that August is a long time ago. You may think that since we have been in the shelter of these halls here in the Senate that people have forgotten about those two issues, and they haven't forgotten. However, I have to say that is not why I am here tonight.

TRIBUTE TO BILLY JOE DAUGHERTY

Mr. INHOFE. Mr. President, I lost a very dear friend of mine named Billy Joe Daugherty a few days ago. I never thought I could sit in one chair for 4 hours, but I did this past Monday. Yesterday they had a memorial for Billy Joe.

He is a guy who as a very young man came to Tulsa, OK. He built one of the largest churches in the Nation. He has been all throughout the Soviet Union—at that time it was the Soviet Union—and throughout the world, and he has been saving souls. This guy was just fantastic. When he died last week, he was only 57 years old. I sat there—I actually sat there, I say to the Chair, for 4 hours in one chair. I didn't think I would be able to do that because I normally am not that patient. But as people started giving talks and the eulogies, the best was saved until last. Billy Joe Daugherty was married for 35 years or so to his wife Sharon. She gave the most beautiful, long speech about her life with Billy Joe Daugherty. Then, one by one, the kids—four kids: John, Paul, Sarah, and Ruthie—stood up and gave tributes. I was thinking: My prayer is that when—my wife and I have been married—two weeks from now it will be 50 years. We have 20 kids and grandkids. By the way, we had all 20 kids and grandkids at one table for Thanksgiving, something that many people are not aware is even possible in this day and age. But my prayer is that when my time comes and I am gone, that my kids will revere me as much as Billy Joe Daugherty's kids revered him.

I remember back in 1978—Billy Joe died last week when he was 57—he would have been about 26, 27 years old. I was mayor of the city of Tulsa. I was elected for the first time. I served three 2-year terms. I am a morning person. I don't do very well at night. In the morning I perform pretty well. I had a policy—and I lived it all the way through those three terms as mayor of Tulsa—that I would open up the city hall at 6 o'clock in the morning and I would make sure no one else was there—no security, nobody else—and stay until 8 o'clock so that everyone knew they could come down and visit with the mayor for 2 hours every day if anyone wanted.

Not many of them got up that early. The first visitor I had back in 1978 was kind of a skinny kid, who came in and said, ''I'm Billy Joe Daugherty, and I want to pray with you.'' That is the first time I ever met the guy. I cannot tell you that he came by every week for those 6 years, but he was a regular who was always showing up. We did pray for each other, for our families, and for the city of Tulsa.

I can remember a favorite verse that he used most of the time, a most common verse, the 23rd Psalm:

> The Lord is my Shepherd; I shall not want.
> He maketh me to lie down in green pastures:
> He leadeth me beside still waters.
> He restoreth my soul:
> He leadeth me in the paths of righteousness for His name sake.

The path of righteousness. Billy Joe was led by Jesus down the path of righteousness probably two, three decades ago. I cannot tell you how many thousands of people Billy Joe has led down that path of righteousness.

> Yea, though I walk through the valley of the shadow of death,
> I will fear no evil: For thou art with me;
> Thy rod and thy staff, they comfort me.

I am sure that when Billy Joe went through that valley of the shadow of death, he probably, knowing him, wasn't even walking. He was probably running because he knew what was on the other side.

> Thou preparest a table before me in the presence of mine enemies;
> Thou annointest my head with oil; My cup runneth over.

Here was the good part. Billy Joe said this:

> Surely goodness and mercy shall follow me all the days of my life.

He might have changed that and said: Surely goodness and mercy and Sharon will follow me all the rest of my days. Whatever it was, they did it together. He led a life—in 57 short years—that accomplished more than most people who will live to be a hundred.

The final words of that verse were:

> And I will dwell in the House of the Lord forever.

I could look at you folks here today and tell you I don't think Billy Joe Daugherty is in heaven, I know Billy Joe Daugherty is in heaven. He is looking down at us and thinking two things. First, he is saying: If you only knew what I know now. And then you have to keep in mind the other thing—Billy Joe is in a different time zone now, and he probably said that in just a wink of time, we will all be together. I have every expectation that will happen.

So this is not to say goodbye to Billy Joe Daugherty; this is to say, so long, we will see you soon.

I yield the floor.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:30 a.m. tomorrow.

Thereupon, the Senate, at 8:14 p.m., adjourned until Wednesday, December 2, 2009, at 9:30 a.m.

CONFIRMATION

Executive nomination confirmed by the Senate, Tuesday, December 1, 2009:

THE JUDICIARY

JACQUELINE H. NGUYEN, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA.