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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.

Loving God, You know our weaknesses and the extent of our failure to love You and one another. Look upon us with mercy and use us to heal the hurt in our world. Establish the labor of our lawmakers, strengthening them to honor You by serving others. Let Your life-giving Spirit move them to feel greater compassion for those in need. Use them to remove barriers that divide us, as they help all to live in greater justice and peace. Lord, give our Senators a daily respect and submission to Your will and commands.

We pray in Your sovereign 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 assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 15, 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.

NOTICE

If the 111th Congress, 1st Session, adjourns sine die on or before December 23, 2009, a final issue of the *Congressional Record* for the 111th Congress, 1st Session, will be published on Thursday, December 31, 2009, to permit Members to insert statements.

All material for insertion must be signed by the Member and delivered to the respective offices of the Official Reporters of Debates (Room HT–59 or S–123 of the Capitol), Monday through Friday, between the hours of 10:00 a.m. and 3:00 p.m. through Wednesday, December 30. The final issue will be dated Thursday, December 31, 2009, and will be delivered on Monday, January 4, 2010.

None of the material printed in the final issue of the *Congressional Record* may contain subject matter, or relate to any event, that occurred after the sine die date.

Senators' statements should also be formatted according to the instructions at http://webster/secretary/cong__record.pdf, and submitted electronically, either on a disk to accompany the signed statement, or by e-mail to the Official Reporters of Debates at "Record@Sec.Senate.gov".

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By order of the Joint Committee on Printing.

CHARLES E. SCHUMER, *Chairman.*

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

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RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of H.R. 3590, the health reform bill. There will be 5 hours for debate prior to votes in relation to the following amendments and motion: Baucus, Crapo, Dorgan, Lautenberg. We can never determine for sure, Mr. President, but it appears the votes should start between 5 and 6 o'clock. The Senate will be in recess from 12:45 until 3:15 p.m. today for the weekly caucus luncheons.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, with Americans now really focusing in on the health care debate, it is important to take a step back and recall where we started because somewhere along the way, Democratic leaders took their eyes off the ball.

It is a good time to remember what this reform debate was all about. The goal of this legislation, by all accounts—everyone agreed—the goal was to lower the cost of health care. This is what the President had to say. It is a direct quote:

> The bill I sign—

According to the President—

> must . . . slow the growth of health care costs in the long run.

That was on July 22 of this year. Yet here we are, nearly 5 months later, and the administration's own scorekeeper, the CMS Actuary—the Centers for Medicare and Medicaid Services Actuary—says the Democratic bill will actually drive costs up, exactly the opposite of what the debate was all about in the beginning, and exactly opposed to what the President indicated on July 22, that he would not sign such a bill.

Now, remember, the purpose of reform was to lower people's insurance premiums as well. Here is what the President had to say about that, a direct quote:

> I have made a solemn pledge—

Said the President—

> that I will sign a universal health care bill into law by the end of my first term as President that will . . . cut the cost of a typical family's premiums by up to $2500 a year.

That was the President campaigning for President on June 24, 2007, ''a solemn pledge that I will sign a universal health care bill into law . . . that will . . . cut the cost of a typical family's premiums by up to $2500 a year.''

Yet now we are being told by the administration's own nonpartisan scorekeeper—again the CMS Actuary—that new fees for drugs, devices, and insurance plans will drive up insurance premiums.

The purpose of reform was also to ease the burden on taxpayers. Here is what the President had to say about that:

> No family making less than $250,000 a year will see any form of tax increase.

That was the President on September 12, 2008: ''No family''—not a one—''no family making less than $250,000 a year will see any form of tax increase.''

Yet now we are told by the independent analysts, such as the Joint Committee on Taxation, that taxes will actually go up on those same taxpayers, those making under $250,000 a year.

People who like the plans they have were told they would be able to keep them. Here is what the President had to say about that:

> If you like your current plan—

''If you like your current plan''—

> you will be able to keep it.

Then he said:

> Let me repeat that: If you like your plan, you'll be able to keep it.

That was July 21, 2009, just this summer. Yet now we are told by the independent analysts, such as the Congressional Budget Office, that millions of Americans will lose their employer-based coverage and that millions of seniors will see their extra benefits cut by about half.

Americans are looking at this, and they are truly outraged. The American people are outraged at what is happening. They cannot understand what we are doing. The latest CNN poll says 61 percent of Americans oppose this bill; 61 percent of the American people are saying don't pass this bill.

This bill is completely out of touch with the American public. Think about it: 1 out of 10 working Americans is looking for a job, and Democratic leaders in Washington want to spend $2.5 trillion on a bill that makes existing problems worse. Mr. President, 1 out of 10 Americans is out of work, and yet the majority seeks to pass a bill that makes the existing problems worse. Yet Democratic leaders in Washington are still insisting that we pass this bill.

Even as opposition grows, supporters of the bill are drafting plans and cutting deals to make this bill the law of the land by Christmas—ignoring the wishes of the American people, off in a room somewhere, cutting plans and making deals, trying to figure out some way to jam the American people when they are asking us, overwhelmingly: Please don't pass this bill.

You get the impression that the supporters of this bill think it is about them, about them and their legacies. Well, this is not about them. This is about the American people. This is not about making history. This is about doing the right thing for every single American's health care.

Americans have a message: Higher premiums, higher taxes, higher health care costs are not what they signed up for. This is not what they were promised. This is not reform. Yes, doing nothing is not an option, but making current problems worse is worse.

TRIBUTE TO JACKIE HAYS

Mr. MCCONNELL. Mr. President, I rise to wish a fond farewell to one of the Nation's finest television news anchors, Louisville's own Jackie Hays. After more than three decades in broadcasting, most of it spent in Louisville, Jackie will be retiring, and people throughout Louisville and across Kentucky are sorry to see her go.

The level of respect Jackie has earned in the community is reflected in the many awards she has won over the years. She has received 16—16—Best of Louisville awards, including numerous honors as Best Female News Anchor.

In 2005, she was named ''Best of the Best'' by Louisville Magazine. She has also received the Star Awards from the Women in Radio and Television, and Emmy nominations for her work both in Louisville and Philadelphia.

Jackie has had a lot of wonderful experiences in her career, all in pursuit of getting the best story for her viewers. She reported live from the scene of the bombing at the 1996 Summer Olympics in Atlanta. She interviewed two Presidents; one of them was Ronald Reagan over lunch. And, of course, she has been a fixture in many Louisville homes on the first Saturday of every May, as she has anchored coverage of the Kentucky Derby 25 times.

Once she went up in an F/A–18 Hornet with the Blue Angels, a U.S. Navy flying acrobatic team that has performed in the Kentucky Derby Festival. She flew at 600 knots—that is nearly 700 miles an hour—and was subjected to seven times the normal force of gravity. She may have blacked out briefly with all that force—as the instructor told her most people do—but for the thrill of the ride, and to better tell the story to her viewers, she says it was worth it.

Jackie was born in Paris, TN, right over the border from Murray, KY, and she attended Murray State University on a special Presidential academic scholarship. She was named the outstanding senior in radio and television and began her broadcasting career at a Paducah station while still a senior in college.

After graduating with highest honors, she went on to a full-time position, until moving to Louisville in 1980 to work for WHAS Television. After 5 years, she briefly went to work in Philadelphia, but in 1988 she returned to Kentucky and River City where she has stayed ever since.

For the last 21 years, since returning to Louisville, Jackie has been with WAVE–3 News. She is currently the anchor of that channel's 5 p.m. and 6 p.m. newscasts.

After 32 years in broadcasting, Jackie has earned a well-deserved rest, and I know she is looking forward to spending more time with her husband Paul, their two daughters, and their dogs. Jackie and Paul are avid horse riders, and I hear they just got a new horse named Chipper.

But Jackie will be greatly missed by the people of Louisville and the surrounding area. Every day, through the television, viewers have welcomed her into their homes. Now we should stop and recognize that we have welcomed her into our community and our lives as well. So I just wanted to take this moment to thank her for her incredible career on behalf of Kentuckians everywhere.

Mr. President, I yield the floor.

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.

Dorgan modified amendment No. 2793 (to amendment No. 2786), to provide for the importation of prescription drugs.

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

The ACTING PRESIDENT pro tempore. Under the previous order, there will be 5 hours for debate, with 2 hours equally divided between the Senator from Montana, Mr. BAUCUS, and the Senator from Idaho, Mr. CRAPO, or their designees, 2 hours equally divided between the Senator from North Dakota, Mr. DORGAN, and the Senator from New Jersey, Mr. LAUTENBERG, or their designees, and 1 hour under the control of the Republican leader or his designee.

Who yields time?

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, for the benefit of all Senators, let me lay out today's program.

It has been more than 3½ weeks since the majority leader moved to proceed to the health care reform bill. This is the 14th day the Senate has considered it. The Senate has considered 18 amendments and motions. We have conducted 14 rollcall votes.

Today, the Senate will continue debating the Dorgan amendment on prescription drug reimportation and the Lautenberg alternative amendment to that amendment and we will continue debating the Crapo motion on taxes, for which I have filed a side-by-side amendment as well.

Under the previous order, there will be 5 hours of debate, with each of the following Senators controlling 1 hour: The Senator from Idaho, Mr. CRAPO; the Senator from North Dakota, Mr. DORGAN; the Senator from New Jersey, Mr. LAUTENBERG; the Republican leader and this Senator.

The Senate will recess from 12:45 to 3:15 for party conferences.

Upon the use or yielding back of the 5 hours of debate, which is likely to be between 5 o'clock and 6 o'clock this evening, the Senate will proceed to vote in relation to four amendments in this order: First, my side-by-side amendment on tax cuts; second, the Crapo motion to commit on taxes; third, the Dorgan amendment No. 2793 on drug reimportation; and the Lautenberg side-by-side amendment No. 3156 on drug reimportation.

Each amendment will need to get 60 votes or else be withdrawn.

Upon disposition of these amendments and the motion, the next two Senators to be recognized to offer a motion and an amendment will be, first, the Senator from Texas, Mrs. HUTCHISON, to offer a motion to commit regarding taxes; and, second, the Senator from Vermont, Mr. SANDERS, to offer amendment No. 2837 on single payer.

AMENDMENT NO. 3183 TO AMENDMENT NO. 2786

Mr. President, under the previous order, it is in order for this Senator to offer a side-by-side amendment to the motion to commit, offered by the Senator from Idaho, Mr. CRAPO, and pursuant to that order, I call up my amendment No. 3183.

The ACTING PRESIDENT pro tempore. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS] proposes an amendment numbered 3183.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To protect middle class families from tax increases)

At the appropriate place, insert the following:

SEC. ____. PROTECTING MIDDLE CLASS FAMILIES FROM TAX INCREASES.

It is the sense of the Senate that the Senate should reject any procedural maneuver that would raise taxes on middle class families, such as a motion to commit the pending legislation to the Committee on Finance, which is designed to kill legislation that provides tax cuts for American workers and families, including the affordability tax credit and the small business tax credit.

Mr. BAUCUS. Mr. President, during the Presidential campaign, President Obama promised not to raise taxes on Americans who earn less than $200,000 a year or American families who earn less than $250,000 a year. That was his promise. This bill keeps his promise.

This bill will provide tax credits to help American families, workers, and small businesses to buy quality health insurance plans through new fair and competitive marketplaces called insurance exchanges.

The Congressional Budget Office expects that by the year 2019, 25 million Americans will buy health insurance plans through the new exchanges. The vast majority of those Americans—about 19 million—will receive tax credits; that is, tax reductions, or help paying their copays and other out-of-pocket costs. These tax credits will reduce their health insurance costs by nearly 60 percent.

This bill does not raise taxes on the middle class. This bill is a tax cut for Americans.

Over the next 10 years, the health care reform bill will provide $441 billion in tax credits to buy health insurance for American families, workers, and small businesses—$441 billion in tax credits. Americans affected by the major tax provisions of this bill will receive an overall tax cut of 1.3 percent in the year 2017. That is a total of $40 billion. That is an average of almost $450 for every taxpayer affected. That same year, 2017, low- and middle-income taxpayers who earn between $20,000 and $30,000 a year will see an average Federal tax decrease of nearly 37 percent. I will repeat that. I think it is astounding. People with incomes between $20,000 and $30,000 a year will receive an average Federal tax decrease of nearly 37 percent. In that same year, 2017, the average taxpayer making less than $75,000 a year will receive a tax credit of more than $1,300. In 2019, 2 years later, that tax credit will grow to more than $1,500.

Without this tax cut, many individuals and families will continue to forgo health care because it costs too much. We make it easier for people to buy health care with those tax cuts.

In addition to a tax cut, this bill also represents increased wages in the pockets of millions of Americans. Even my colleague from Idaho agrees that as a result of this bill, Americans will see increased wages. He said that exact thing on the floor last week. As a result of this bill, many Americans will see increased wages.

Senator CRAPO gave the example of an employee, the value of whose health insurance decreased but whose overall compensation did not decrease. As a result, the employee would receive additional wages.

Why are workers going to complain that they are paying more in wages because they have more money in their pocket? If incomes are going up, their wages are going up. Clearly, their taxes are going to go up correspondingly, but obviously the taxes are not going to go up by as much as the wages.

I have a letter from the Congressional Budget Office, dated November 18, that states just that. On page 18, the Congressional Budget Office says:

If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current law projection), the Congressional Budget

Office and the Joint Committee on Taxation assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same.

I have a chart behind me that shows that very point for each of the years this bill is in effect. Looking, first, over to the left—the chart shows from 2013 up to 2019, but on the far left, the green is the percent of total tax revenue due to increased wages. That is wages increasing. The white is the percent of total tax revenue due to excise taxes, the increased taxes the person will have to pay. Wages far outstrip the taxes. The increase in wages is far greater, according to the Congressional Budget Office and the Joint Committee on Taxation.

Just to repeat, as that chart illustrates, the overwhelming majority of revenue raised from the high-cost insurance excise tax will come from increased wages. Only 17.5 percent of the revenue will be attributable to the excise tax. The rest, more than 82 percent, will come from employees getting more than their compensation wages and less in inefficient health coverage.

I urge my colleagues to recognize the Crapo motion to commit for what it is—and what is that? It is an attempt to kill health care reform. That is all it is all about, nothing more, nothing less. Senator GRASSLEY said as much last week. Senator GRASSLEY asked us to vote in favor of the motion to commit ''to stop this process right now.'' That is a direct quote.

We must not stop this process. We must not stop moving forward in our efforts to reform health care. Indeed, we must move forward aggressively. Every day we delay, 14,000 Americans lose their health insurance. Every day we delay, 14,000 Americans lose their health insurance. In just a 2-week period, one in three Americans will go without health care coverage at some point. We cannot afford to stop working toward reform. We must reject any attempt to eliminate the very provisions from this bill that provide Americans with a tax cut in an attempt to stop health care reform. Despite Republican claims that they are trying to protect Americans from tax increases in this bill, the facts are this bill is a tax cut for most Americans.

On a related matter, there has been some discussion about the Office of the Actuary analysis of the Senate bill. Let me cover two very key points from that letter.

The Actuary at HHS concludes that this legislation extends the life of the Medicare trust fund by 9 years—9 years. We know the Medicare trust fund is in a precarious position until, roughly, 2017. There are some estimates that this underlying bill would increase the solvency of the trust fund for 4 to 5 more years, say to 2022, roughly. The Actuary, the person who number crunches over at HHS, concluded this legislation will extend the life of the Medicare trust fund by 9 years. That is no small matter. Seniors, near seniors, are very concerned about the solvency of the health care trust fund. This legislation extends the solvency of the health care trust fund by 9 years.

So just think, if this legislation is not passed, the solvency of the health care trust fund will not be extended by 9 years. The Actuary says, the Medicare trustees say it will probably start to become insolvent, the Medicare trust fund, the Medicare trust fund will become insolvent in just a few years—2017. Clearly, it is very important to extend the solvency of the Medicare trust fund. How does this legislation extend the solvency of the trust fund? It is very simple. We cut out a lot of the waste. We cut out a lot of the inefficiency. We make the system work better so the fund is extended for 9 more years.

In addition, the Actuary says this legislation, by the year 2019, will result in about a $300-per-couple reduction in Part B premiums. In addition to that, the Actuary concludes the legislation will result in about a $400-per-couple deduction in cost sharing. If you add the two together, that is about $700. So by the year 2019, as a result of this legislation, according to the Actuary—it is in black and white there—it says right there, in print, there will be about a $700 reduction in premium Part B and out-of-pocket costs for seniors. That is no small matter. It is a reduction.

On the other side of the floor, we sometimes hear all this rhetoric about increases. It is just that—it is rhetoric. The actual analysis shows a reduction.

I also hear rhetoric on the other side about this legislation resulting in increased premiums for people. Not true. The Congressional Budget Office has concluded that for 93 percent of Americans, there will be a reduction in premiums—a reduction in premiums. To be fair, for those who are already employed, the reduction is not huge, but it is a reduction, nevertheless. It is about a 3-percent reduction in premiums. That is a reduction. We have to keep working to make it an even greater reduction. I daresay—in fact, I know as sure as I am standing here—the reduction will be greater. Why will it be greater? Because a lot of the provisions in this legislation—in my view, the Congressional Budget Office hasn't fully analyzed provisions such as delivery system reforms. We start to bundle competent care organizations. We start pilot projects. The result of that will be a reduction in costs and therefore a reduction in premiums.

Also not calculated is the Commission which will look at productivity. That is not included in the CBO analysis. If that were included in the CBO analysis, the reduction would be even greater. We are talking about the remaining 7 percent—remember, I said 93 percent would get a reduction in premiums according to CBO. The remaining 7 percent don't get a reduction, but what do they get in return? They get much better insurance because we have insurance market reform in this legislation. No more preexisting conditions. No more rescissions. No more denial based on health status. No more company limitations on annual losses. No more limitations on lifetime losses. So for the same premium, they are going to get a lot better quality. Instead of buying a used car, they are going to get a new car for roughly the same price.

So the analysis of this legislation is very clear: Reduction of premiums, CBO says so; extension of solvency of the trust fund, CBO and the Actuary say so; a reduction in premiums and out-of-pocket costs for a couple by $700 by the year 2019. That is what the Actuary says.

So this legislation lives up to the promise we made earlier. It does not raise taxes for people making under $200,000. I think the legislation should clearly be passed.

Let me say this too. Someone once said—and I will conclude here—that the status quo is really not the status quo. If this legislation is not passed, the result is not the status quo; the result is we move backward. We have two choices. Either we move forward as a country and seize this opportunity to tackle health care reform and do our very best to get it right or we don't; we do nothing, and we keep sliding backward. Think of the repercussions of not passing this legislation. Think of it. First of all, tens of millions of people will not have health insurance. That, in itself, is pretty profound. Second, we will not have health insurance market reform. We will still have denial based on preexisting conditions, which is basically what the other side is arguing for.

We would not cut down health care costs, which our businesses need so much, and families need so much, and our budgets need so much. Remember, I mentioned the legislation extends the solvency of the Medicare trust fund.

That is emblematic of some of the savings that we have in other government programs, too, because health care costs are rising so much. Medicare is in tough shape, and so is Medicaid because health care costs are rising so much. The CBO and the Actuary say we are controlling health care costs.

The PRESIDING OFFICER (Mr. BEGICH). The Senator from Idaho is recognized.

Mr. CRAPO. Mr. President, I ask unanimous consent to speak for up to 40 minutes and to use that time in a colloquy with other colleagues.

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

Mr. CRAPO. I also ask to be notified when there are 5 minutes remaining.

The PRESIDING OFFICER. The Chair will do so.

Mr. CRAPO. Mr. President, I am going to engage in a colloquy about the pending motion on which we will vote later this afternoon or early this

evening. It is a motion to commit the bill to the Finance Committee and have the Finance Committee make the bill comply with the President's pledge. Here is the pledge:

> I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase . . . not your income tax, not your payroll tax, not your capital gains tax, not any of your taxes.
>
> . . . you will not see any of your taxes increase one single dime.

I heard my colleague from Montana say the bill complies with this pledge. If that were true, then there would be no harm in having the Finance Committee scour through it and make sure it does and refer the bill back to make sure it doesn't tax the middle class.

The reality is, it is very clear this legislation violates this pledge of the President. As a matter of fact, there are over $493 billion of new taxes in this bill meant to offset the $2.5 trillion during the first full 10 years of implementation of spending in the bill.

If you will look at the next chart, at the graph on taxes, the first 10 years—this includes the fees also imposed that CBO and Joint Tax said will be passed right on through to the consumer. There are $704 billion of taxes and fees in the first 10 years of the bill. If you look at the 10 years of full implementation, meaning when the spending actually starts, the taxes and fees are actually $1.28 trillion.

My colleague says this is a net tax cut bill, and it complies with the President's pledge because when you take all of the refundable tax credits in the bill and offset against the tax increases, there is a net reduction in tax. In the first place, that is not true when you take into account the fees. I don't think that is what the President was talking about. He didn't mean, did he, that you will not see your taxes go up more than someone else's taxes go down? No, he told people in America they would not see their taxes go up.

Yet what this bill does, according to the Joint Tax analysis, is, by 2019, at least 73 million American households earning below $200,000 will face a tax increase.

If that is not violating the President's pledge, I don't know what is—even if you take the numbers that the majority is trying to use and claim that those are tax cuts.

Here is the next chart. What my colleague from Montana is talking about is about $400 billion of what are called refundable tax credits. He wants to offset these tax credits in the bill against the hundreds of billions of dollars of tax increases, and then say there is a net tax cut and, therefore, no problem.

First of all, that is a problem. Secondly, what is a refundable tax credit? The $288 billion, or 73 percent of the so-called tax credit—or tax cuts that my colleague from Montana is talking about—are payments by the Federal Government to individuals or families who do not have tax liability. It is a direct government subsidy. The CBO scores these payments as a Federal outlay, as spending, not as tax relief, and that is exactly what it is. I think it is a little bit less than credible to say that we have a tax cut bill when three-fourths of the so-called tax cuts don't even go to reduce tax liability for taxpayers.

Mr. ENSIGN. Will my colleague yield?

Mr. CRAPO. Yes.

Mr. ENSIGN. Would the CBO—which is nonpartisan—score a welfare payment the same as these so-called tax credits?

Mr. CRAPO. Yes, that is right. A payment of a subsidy to an individual in the United States would be scored as a Federal outlay, or spending, as is a refundable tax credit paid to an individual who has no tax liability.

Let's assume we even accept the argument that is a tax cut. Even if you offset all of that, remember the chart a minute ago that said 73 million people would pay taxes. Even if you give them credit for that argument, there are still going to be 42 million people making less than $200,000 a year who will face a net tax increase. That is a violation of the President's pledge.

All this motion does is send the bill back to the Finance Committee, which writes tax policy, to correct that. The motion helps this bill comply with the President's pledge.

The Senator from Montana also used another example, trying to say some of these people who are paying more taxes are getting higher wages. This is the game that is going on. The employer of these people the Senator was talking about today provides a salary and health care to that employee. In this example, it is $50,000 of wages and $10,000 of health care benefits. This bill will now impose a hefty 40- or 45-percent tax on this health care plan because it is too good of a health care plan.

What CBO and Joint Tax tell us is that because of that immense tax—40- to 45-percent tax—the employer is just going to cut the health care plan down to where it is not taxed anymore and provide those dollars with an increased wage. So this young lady will get maybe $53,000 in wages instead of $50,000 and only $7,000 of health insurance, and her net employment compensation will still be the same, $60,000—except she will pay taxes on an extra $3,000. So her net employment package will go down not up, and 73 million Americans like her will end up with a smaller employment package, less health care benefits, and increased Federal tax liability. That is the way the bill works.

For issue after issue, there are taxes after taxes in this bill that will be paid by the people in this country who earn less than those on the threshold the President identified. That is why we simply ask that the bill be sent to the Finance Committee to have this violation of the President's pledge, this bad policy of increasing taxes on the middle class in America to pay for a huge new government entitlement program, be removed from the bill.

Mr. BARRASSO. Mr. President, I ask my colleague this: I was reading a national publication yesterday, and the headline is ''Making Nightmare Out Of Health Care.'' It says taxes will go up. This also says the proposed overhaul contains, at last count, 13 different tax hikes. It goes on to say the Joint Tax Committee said that for any one person who may end up paying lower taxes, there will be nearly four times as many—close to 70 million people—who will pay higher taxes.

That is why I have been waiting for a week now to vote for the Crapo motion. This was introduced last Tuesday. A whole week has passed, and the Democrats have been filibustering and preventing us from voting on this very important amendment, which the American people agree with—that we ought to eliminate these taxes and stick with what the President promised the American people.

As a result of the President's promises, I read a recent CNN poll. It says that 61 percent of Americans oppose this bill the Democrats are proposing. It gets to the specific question of tax increases and the President's promise. It says:

> Do you think your taxes would or would not increase if this bill passes?

And 85 percent of the Americans polled said they believe their taxes will go up.

I ask my friend from Idaho—it seems to me the American people get it; they realize they are going to be hit hard with this $500 billion of tax increases, 13 different taxes, which will get put on the backs of the hard-working people of our country.

Why is it that we are not allowed to vote on this motion? I will vote for it. I appreciate the Senator from Idaho bringing this motion forward because, clearly, the support of the American people is behind him.

Mr. CRAPO. I thank my colleague. I will give some statistics on the point. The Joint Tax Committee analyzed just the four biggest tax provisions—not all of them—and they concluded that only 7 percent of Americans would be receiving these so-called tax cuts, which are really spending subsidies but have been characterized as a tax cut in order to argue that the bill doesn't increase taxes. Only 7 percent of Americans will receive those, which represents about 19 million people, but 157 million people—almost 8 times that amount—who get health insurance through their employer will not be eligible for these credits. They will pay, on average, somewhere between $593 to $670 a year, depending on their income categories, in new taxes that are put on their shoulders in this bill.

I notice that my colleague from Tennessee wants to say something.

Mr. ALEXANDER. Mr. President, I congratulate the Senator from Idaho

for his amendment to help the President keep his commitment. That is basically what it is. I would think our friends on the other side would all want to join us in that. The President said he would not raise taxes on people making less than $250,000 a year.

It is amazing to hear the comments that I have just heard. The whole construction of the bill—when we think about it, regardless of whatever the Democrats decide to do about the so-called public option, they still seem determined—at least the majority leadership seems determined—to engage in this political kamikaze mission toward a historic mistake. There is all this talk about history. But there are lots of different kinds of history.

A lot of historic mistakes have been made about taxes. For example, there was the Smoot-Hawley tariff of 1930, which was a big tax. It sounded like a good idea. President Hoover, a Republican, recommended it to protect American jobs by keeping out cheaper foreign products. That led us into the Great Depression. It was a historic mistake. More recently, there was the boat luxury tax. This sounds good. It was part of the budget deal of 1990. Congress put a 10-percent luxury tax on boats costing more than $100,000. Sound familiar? We were going to hit the rich people. But it got the working people, not the rich people. The unintended consequence was that it sank the boat industry, costing 7,600 jobs, according to the Joint Economic Commission, and Congress repealed that historic mistake. There was also the Medicare Catastrophic Coverage Act of 1988, another good-sounding goal, to help older people reduce the risk for illness-related catastrophic financial losses. But a lot of our senior Americans resented the idea of paying additional taxes for that coverage, and they revolted. Congress, less than a year and a half later, repealed it.

We all remember the millionaires tax. That is a matter of history. In the late 1960s, there were 155 high-income Americans who weren't paying any Federal income taxes, so Congress imposed something called the alternative minimum tax. Last year, that affected 28 million American taxpayers.

I say to my friend from Idaho, I think he is doing the country and the President a great service by offering this amendment to help keep the promise because whatever the majority leader decides to do about the government option, this legislation—when fully implemented—still contains $1 million in Medicare cuts 5 years before Medicare is scheduled to go broke, according to their trustees.

It is nearly $1 trillion in new taxes over 10 years when fully implemented, as the Senator from Idaho has pointed out. There is no question about that, it is an increase in premiums for most Americans, according to the Congressional Budget Office. And yesterday on this floor, we talked about the huge bill we are about to send to States to help pay for this in the Medicaid Program.

It is important to support the Crapo motion. It is important for our country not to have this historic mistake thrust upon them.

Mr. ENSIGN. I would like to jump in here and ask the Senator from Idaho a question. From what I understand, the taxes go into effect—actually, this is from yesterday, so I think it would be in 17 days from now based on the current bill before us. All of these taxes the Senator from Idaho has on his chart are all the taxes the President said he would not violate. The article yesterday said 13 taxes. We know of at least nine absolute taxes that would go into effect. But the tax subsidies, these payments to folks who do not have a tax liability, those are not received for 1,479 days; isn't that correct?

Mr. CRAPO. The Senator from Nevada is correct. The fact is, the taxes start on day one of the bill. The spending, which is what these alleged tax cuts are that my colleague from the other side was talking about, does not start until the fourth year or 2014. And that is just one of the gimmicks in the bill in order to claim it does not drive up the budget—have 10 years of tax increases and only 6 years of spending to offset against it. I think that is how they started the spending days. They figured out how long they had to delay it so they could claim it would not drive up the deficit.

Mr. ENSIGN. I want to address one of these taxes, the so-called Cadillac tax that the Democrats have put into this bill. The problem is, they did not index it for inflation. As time goes forward, with the red line as the threshold, the Democrats indexed it for what is called the consumer price index plus 1 percent. That goes up a little bit. The problem is, medical inflation is going up much faster. What happens is—the blue line is the average plan in the United States—that is how fast it is going up. We can see that is much higher. At this point, it starts catching most of the plans in the United States.

This 40-percent tax the unions are running ads against right now is going to start getting almost all Americans' plans in the future. That is the reason a lot of people do not realize this is a tax. It may not get them today, but it is going to get them eventually. What is going to happen is this tax will be passed on to them in lower benefits.

Mr. CRAPO. The Senator from Nevada is correct.

Before I toss the floor to the Senator from Texas who wants to make some comments, I point out that the point the Senator from Nevada made is statistically made by Joint Tax:

> By 2019, at least 73 million American households—

That is not 73 million Americans, that is 73 million American households—

> earning below $200,000 are going to face these tax increases.

Mrs. HUTCHISON. If I may respond to the Senator from Idaho. I was thinking, when the Senator from Tennessee was talking, about the luxury taxes and how everyone thought that felt so good to have a tax against luxury boats. And who suffered? The workers. Then there was the catastrophic Medicare coverage which resulted in a tax on seniors who had that coverage. Seniors erupted, and that was repealed. Then that is followed on by what the Senator from Nevada talks about—the Cadillac plan, which is the high-end plan of coverage.

I thought, maybe Congress has learned something. Maybe the Democrats are on to something. They have listened to the history of all of these good-sounding taxes on rich people or people who buy expensive things. As the Senator from Nevada has pointed out, they have now learned they probably ought to go ahead and tax both ends instead of just the high end because in this bill, you have a tax on the high-end plans. You have a tax on employers who provide too much coverage. Oh, but we also tax the people who do not have any coverage. If it is too small, you get taxed, and if it is too big, you get taxed. It seems that maybe the Democrats learned the wrong lesson. It is not that you tax just the rich or the people who buy expensive things, it is that you tax both ends to make sure you get every little drop of taxpayer dollars.

I think we have shown on this floor from the endless hours of debate that everyone in America is going to be taxed because the taxes that take effect in 3 weeks' time under this bill, January of 2010—the major tax increase takes place, and that is the tax increase on prescription drugs; on insurance companies that are going to have to raise their premiums; the drug costs are going to go up; and medical equipment, which is essential for seniors, especially for everyone who needs some form of equipment, the equipment manufacturers are going to have a tax. Mr. President, $100 billion in new taxes starts next January, 3 weeks from now. Every person in America is going to pay taxes in the form of higher prices starting in 3 weeks.

The Senator from South Dakota and I are sponsoring legislation because the next question will be: Oh, my goodness, if we are going to be taxed in 3 weeks, surely we are going to have some sort of benefit offered in 3 weeks, some sort of low-cost health plan or option. Three weeks, surely. Oh, no, we are not going to have any of the plan that would offer options to people—not in 2010, not in 2011, no, not in 2012, not in 2013, but 2014.

So all these higher prices are going to start kicking in in January, and then we are going to have the Cadillac plan that the Senator from Nevada mentioned in 2013, all being paid before one supposed benefit would be available. If this is not a bait-and-switch, I have never seen one.

The Senator from South Dakota and I are going to offer the next amendment after the ones that are in the

tranche right now to very simply say: Whatever the bill is in the end, there will be no taxes until there is a plan. Not one dime of taxes could take effect until there is actually some sort of plan available that would, hopefully, give some sort of benefit to people, which is what is being promised.

I ask the Senator from South Dakota if that is his understanding, that we would at least draw a line. Whereas Senator CRAPO's motion, which I support and I know everyone on the floor talking this morning supports, is to say there will be no taxes to anyone who makes under $200,000. But even if there are taxes in the end, they will not take effect until there is some sort of plan available for people that is going to help Americans who do not have coverage and for whom we are not able to lower the cost, which is what the Republicans are trying to do. At least we would set that deadline.

I ask the Senator from South Dakota what he has been hearing about this bill.

Mr. THUNE. My colleague from Texas is exactly right. Her motion and the motion I am cosponsoring, which we hope to vote on next, will be a follow-on motion to the motion the Senator from Idaho is offering.

It seems a basic principle and a matter of fairness to the American people that if you are going to create public policy, that you do it in a way that treats people fairly and does not raise their taxes before a single dollar of the premium tax credits and the exchanges that are designed to create the new insurance product for people would take effect. That is what this bill does.

The motion of the Senator from Idaho commits all of the tax increases—and I will support that wholeheartedly, and I hope my colleagues in the Senate will do the same because these tax increases are the absolute worst thing we can do at a time when we have an economy in recession and we are asking small businesses to lead us out of the recession. Seventy percent of jobs in the country are created by small businesses. It is much higher in my State of South Dakota. These tax increases could not be more poorly timed in terms of getting the economy restarted and creating jobs for Americans and getting them back to work. Since most people get their insurance—at least currently—through their employer, one of the best things you can do to provide insurance is to put people back to work. This bill has the opposite effect. It is a job killer because of all of the tax increases. Every small business organization has said that. That is why it is so important we support the motion of the Senator from Idaho.

Senator HUTCHISON and I will also offer a motion—hopefully, we will get a vote on it later—that at least will delay the tax increases until such time as the benefits begin. It essentially aligns the revenue increases and the benefits so they are synchronized and you do not have this period of 10 years where you are taxing people for 10 but only delivering a benefit for 6. Again, I think that violates a basic principle of fairness most Americans should expect when it comes to their elected leaders making public policy which will have a profound impact on them and their lives. I certainly hope we get a vote on that motion, and I hope our colleagues will support it. To me, it is unconscionable that you would raise taxes by $72 billion, which is what this does, up until the year 2014 before the premium subsidies and the exchanges kick in which would deliver the benefits that are supposed to be delivered under this bill. The Senator from Texas and I look forward to getting a vote on that motion.

I hope we can win on the Crapo motion later today.

I appreciate my colleagues being here to point out how important it is that we have public policy that is fair and also that we not do things that are counter to job creation at a time when we are asking small businesses to get out there and create jobs and make investments.

Mr. BARRASSO. The Senator from Idaho had a picture of a woman making $50,000 and the health benefits that resulted. My concern is not just her taxes; my concern is also her job. It is also a fact that she would still have a job.

What I hear from the people of Wyoming is: Don't raise my taxes, don't cut my Medicare, don't make matters worse than they are right now in this economy where we have 10-percent unemployment.

Like the Senator from South Dakota, I am a member of the National Federation of Independent Business. I have been a member for years. They are telling us that as these taxes are raised and collected in 2010, 2011, 2012, 2013, in 2010 we are going to lose 400,000 jobs in America, and in 2011 another 400,000, and another 400,000 after that, and another 400,000, as the taxes continue to be collected. So we would be losing in this country 1.6 million jobs as a result of these increased taxes all Americans are going to have to pay.

I ask the Senator from Idaho, isn't it even more critical that we pass his motion in addition to the fact that we do not want these taxes? They are going to hurt our economy across the board.

Mr. CRAPO. The Senator from Wyoming is exactly right. It is the wrong thing to do when our economy needs to be strengthened and restarted, if you will, to apply a huge amount of new taxes.

Let's take the example we talked about earlier. This young lady, under the bill in the Senate right now, will not only see her health benefits go down, but the net value of her compensation package will go down. She will get a little extra wages in order to offset the reduction of her health care benefits, but those will be taxed and her net compensation package will go down.

The point here is this—and it is a little bit ironic that today the Democratic caucus is going to be meeting with the President at the White House in yet one more closed-door meeting where they are going to be trying to redraft the bill in order to get around some of the problems, which I hope they will let the American people see to debate before they try to vote on it again.

It is ironic, as Democrats come out of that caucus, if they do not support this motion, they will be violating two of the President's pledges. One, after meeting with him, they will be violating his pledge not to tax Americans who make less than $200,000—$250,000 for a family—as well as his pledge: If you like it, you can keep it.

This young lady, if she likes her package, cannot keep it. She will not have that option. Her $10,000 health care package will be reduced at least $2,000 to the minimum new government-designed acceptable policy and probably a little more than that. She will see a 20- to 30-percent reduction in her health care package against her will. I would be willing to bet she would prefer to keep the one she has now. Most Americans like the insurance they are getting through their employers.

Mr. ENSIGN. I would like to ask the Senator from Idaho a question. These are the nine taxes we know for sure that are being raised: 40 percent Cadillac plan, a separate insurance tax, an employer tax, a drug tax, a lab tax, a medical device tax, a failure to buy insurance tax, the cosmetic surgery tax, and the increased employee Medicare tax.

In our States, people think we will pass a sales tax, and the business will just pay the sales tax. I ask the Senator from Idaho, who actually pays the sales tax? Who have the Congressional Budget Office and the Joint Committee on Taxation, which are both nonpartisan, said are going to pay these taxes?

Mr. CRAPO. The Senator was there when the Joint Tax and CBO experts were asked this question. They squarely and directly said these taxes and fees will be passed on, virtually 100 percent, to consumers, which means two things. First, the ones that are taxes will just be taxes passed on to the consumer, as shown in the example of the young lady we looked at. The ones that are fees will simply be passed on in the form of higher costs for medical services or higher premiums, which is one of the reasons why, contrary to the assertions by the other side, this bill will drive up the cost of health care and will drive up the cost of premiums, not down.

Mr. ENSIGN. The last thing I would like to point out goes along with the Senator's chart. This is what the Joint Committee on Taxation has said: 84 percent of all the taxes being paid in this bill are being paid by those making less than $200,000 a year. If this is

not a direct violation of the President's promise not to raise one dime of their taxes, I don't know what is. I don't understand how the President can sign this bill and keep to the promise he made during the campaign.

Mr. CRAPO. I agree with the Senator from Nevada. It is disturbing to see the responses. First, the response that this bill actually doesn't increase taxes; it cuts taxes. That flies right in the face of the reports and analysis by Joint Tax and CBO. I encourage everybody to read this bill. It is available on my Web site and on the Republican Web site and on the C–SPAN Web site. In addition, we will put up a reference to where you can find the bill to read it if you want to parse through it to determine who is telling the truth. The bottom line is, this bill increases taxes in the first 10 years by $493 billion. When you add fees to that, it is more like $700 billion. If you counted the first full 10 years of implementation, it is over $1 trillion of new taxes. The only response to that is to try to say that the subsidies for health insurance for those who are not able to purchase their own insurance are tax cuts, even though three-fourths of them go to those who are not, at this point, at a level where they are incurring a tax liability.

Mr. THUNE. My understanding is, those premium tax credits actually go to the taxpayer. When you say this is a tax cut for people, does it end up in the pockets of the average taxpayer?

Mr. CRAPO. The Senator from South Dakota is correct. In fact, this subsidy is not paid to the individual. It is paid directly to the insurance company. Of the one-quarter of people receiving this subsidy who do actually pay income taxes, their income taxes will, in fact, stay the same. They are not actually getting a tax cut. What they are getting is a subsidy for the purchase of insurance that is managed through the Tax Code but is paid directly to the insurance company.

Mr. THUNE. That is precisely why the arguments made by the other side that somehow this is a tax cut sort of defy what I think most Americans have come to expect when they get a tax cut; that is, that they get to keep more of what they earn. What we are talking about is a payment that will be made to an insurance company, a tax credit for premium subsidies that will go to an insurance company. There will be very few Americans, as a percentage of the total population, who will actually derive any sort of benefit. My understanding is, about 10 percent of all Americans will get some benefit from the premium subsidies that will go to the insurance company, not directly to the taxpayer; is that correct?

Mr. CRAPO. It is actually 7 percent.

Mr. THUNE. So we have a very small number of Americans who will derive a benefit. But you have a whole lot of Americans who will actually be paying the freight. The Senator mentioned earlier—I saw his chart—that 73 million Americans are going to end up with higher taxes as a result. Many of the premium tax credits, if you could give credit to the taxpayers receiving this, which you can't because it goes to the insurance company, but if you could, three-quarters of that will go to people who currently have no income tax liability. It seems as if the advertising on this is very inconsistent with reality and the facts. The fact is, most Americans will see taxes and premiums go up. Very few Americans are going to get some premium tax credit to help subsidize their premium cost, and that will go directly to the insurance company. I understand the Senator from Idaho and the Senator from Nevada are both members of the Finance Committee. They have been involved with this from the beginning. That is my understanding of this, which is hard to fathom how that constitutes a tax cut.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Idaho has consumed 35 minutes.

Mr. ALEXANDER. I agree with the Senator from South Dakota. People who might be watching this must be thinking: Wait a minute. Let me ask the two members of the Finance Committee: What the Democrats are trying to say is, a Medicare cut is not a Medicare cut and that a tax increase is not a tax increase and that a premium increase is not a premium increase. Isn't it true that when the bill is fully implemented, there will be nearly $1 trillion in Medicare cuts, and isn't it true that there will be nearly about $1 trillion, when fully implemented, in new taxes? Isn't it true the Congressional Budget Office has said that will all be passed on to people? Isn't it true that all the taxes start in January, if the bill passes? Isn't it also true the Congressional Budget Office has said premiums are going to continue to go up and, for people in the individual market, they will go up even more? Isn't that all true?

Mr. CRAPO. I will respond first. The Senator from Tennessee is exactly right. Again, on this chart, these are the tax increases for the first 10 years of the bill, and this chart includes the fees and penalties that are charged as well. The total there is $704 billion. If you start when the bill becomes implemented or is started to be implemented, in 2014, to compare taxes to spending, the actual taxes and fees that will be collected are almost $1.3 trillion.

Mr. ENSIGN. There is no question. I can answer the Senator's question: True, true, true, and true. The old saying, if it walks like a duck and it quacks like a duck, it is a duck. These taxes sometimes are called fees. The Supreme Court has ruled that a fee that acts like a tax is, in fact, a tax. Most of the provisions we talked about before, we call them a tax, and that is what they are. These nine new taxes are a tax. You are exactly right. The Joint Committee on Taxation and the CBO have said these are going to be passed on to the consumer. What they have also said—and I thought this was significant—is that 84 percent of all these taxes are going to be passed on to people who make less than $200,000 a year. That is what we have been saying. The other side says: We are just going to tax the rich. When 84 percent of that tax burden is paid by people making less than $200,000 a year and the vast majority is also paid by people making less than $100,000, the vast majority is being paid by people who make less than $100,000 a year, the same as sales taxes. The sales tax has been called a regressive tax. These are regressive taxes the Democrats are passing on to the American people.

Mr. CRAPO. I thank my colleagues for coming over and speaking today and discussing this issue with me. I would like to conclude by pointing out, once again, the President said he could make a firm pledge, no family making less than $250,000 will see their taxes increase, not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes. You will not see any of your taxes increase one single dime. But there are hundreds of billions of dollars in tax increases in this bill that are going to fall squarely to the backs of the middle class.

Our motion simply says: Let's fix that and take it out. The bottom line is, those who are saying that is not the case are trying in the first case to say there are subsidies in the bill that almost equal the amount of these taxes and, therefore, it is a net tax cut. First, subsidies are not tax cuts. Three-quarters of them go to individuals who have no tax liability. The other one-quarter does not reduce the tax liability of the individuals who are getting the insurance subsidy. Even if you accept all of that argument, the President was not saying you will not see net taxes go up in America. The President was not saying: We will not cut or not increase your taxes by more than we will cut someone else's taxes. I don't think anybody expected that was what he was saying. The President was saying he would not raise taxes in this bill. This bill violates that pledge.

Therefore, Members should support the motion to send this bill back to the Finance Committee to fix that glaring problem.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. I suggest the absence of a quorum and ask unanimous consent that the time be divided equally.

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

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. I ask unanimous consent that the order for the quorum call be rescinded.

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

The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent to speak on the

time allotted to the chairman of the Finance Committee relative to his amendment.

The PRESIDING OFFICER. The Senator is recognized.

Mr. DURBIN. Mr. President, there has been a lot of talk about taxes and health care. What we are discussing is this bill. It is a large bill, over 2,000 pages, but we needed all these pages because we are tackling one of the biggest problems facing America. How can we take a health care system that consumes $1 out of every $6 or $7 in our economy and change it for the better, keeping what is good but changing those things that are not so good? One of the things that concerns most of us is the cost of health insurance premiums. Ten years ago, an average family of four paid $6,000 a year for health insurance. Now that is up to $12,000. If we are not careful, in 8 years it is projected to double again to $24,000 a year for health care premiums. Think about that, trying to earn $2,000 a month in 8 years just to pay for your health insurance, nothing else. That is beyond the reach of individuals and beyond the reach of a lot of businesses. Even today, businesses are dropping people from coverage.

We now have some 50 million Americans without health insurance, and more and more businesses are just putting their hands up and saying: We can't go any further in paying higher premiums.

Individuals who go out on the open market know what they run into. You know you will run into the highest possible premiums and rank discrimination. Try to buy a health insurance policy if you have any history of illness. They will tell you: We are not covering that. Cancer in your background; we will not cover it. That is what people face. This current system is unsustainable. We have tackled it, and we said we are going to put the time in to change it for the better. This is our bill.

I would like to hold up in my other hand the Republican plan for health care reform, but it doesn't exist. They don't have a plan. They have speeches. They have press releases. They have charts. But they don't have a plan. I am talking about a plan that has gone through the rigors of being carefully reviewed by the Congressional Budget Office, a plan that is comprehensive, something that addresses all the problems in this system in a responsible way.

They have bills. They have ideas. I don't want to say anything negative about them, though I may disagree with them. But they don't even come close to being a comprehensive plan. Many of the critics on the other side come to the floor every day and give speeches about what is wrong with the Democratic health care plan because they don't have one. If they did, we would have heard about it. You would have thought it would have been the first amendment offered by the Republican side, if they truly have such a plan. Of course, they don't.

What does this plan do? First, it makes health insurance more affordable. We have the Congressional Budget Office telling us: Yes, the projected increase in health insurance premiums is going to flatten; it is going to come down a little. It doesn't mean that automatically people are going to see their premiums coming down next year, but they may not go up as fast. And over time, we won't see them doubling as quickly as had been predicted.

Secondly, this is a plan which is going to mean that 31 million Americans who currently have no health insurance will have health insurance. That is pretty important. In all the criticism I have heard from the other side of the aisle, there has not been a single proposal from the Republican side that would expand in any significant way the amount of coverage for Americans when it comes to health insurance. But here are 31 million Americans who will at least have the peace of mind of knowing when they go to bed in the evening that if tomorrow there is a bad diagnosis or a terrible accident, they will be covered; they will have peace of mind they can go to the best doctors and hospitals in America. That is significant.

There is another element too. We know that right now the health insurance companies really have the upper hand when it comes to negotiating for coverage. You know what I am talking about. Your doctor says: I think you need the following procedure, but I have to check with your insurance company. Think about that. We may be the only Nation on Earth where a clerk working for an insurance company has the last word about life-or-death medical care. That is what is going on today.

This bill makes significant changes when it comes to health insurance. It protects individuals from being discriminated against because of preexisting conditions, makes sure the companies can't run away from coverage when you need them the most, and extends the coverage and protection for children and families. These are important things that are going to mean a lot to people across America.

But now comes the Republican side of the aisle and says: Oh, but they didn't tell you the real story. It is all about your taxes going up. Well, I am afraid that is not quite right. The criticism I have heard on the floor about this bill ignores the obvious: this bill provides the most significant tax cuts in the history of this country—$440 billion in cuts over the next 10 years. What kind of tax cuts? If you are making less than $80,000 a year, this bill says: We will be there to help you pay the premiums. That doesn't exist today. If you don't have coverage under Medicaid and you are buying health insurance and your income is below $80,000 a year—we are providing tax cuts to millions of Americans so they can afford their health insurance, the biggest tax cut, I think, in the last 20 years or more. In addition, there are tax breaks for smaller businesses. If you have 25 or fewer employees, we will help you and your business provide health insurance for your employees. That is significant.

In fact, the Joint Committee on Taxation takes a look at the new taxes charged and the tax cuts that are in the bill, and they say Americans will pay 1.3 percent less in taxes in 2017 as a result of the bill. So the tax burden on Americans starts to come down while insurance coverage goes up.

But don't forget the hidden tax we pay today. When people show up at the hospital without health insurance, they get care. They see a doctor, they may have x rays and all the procedures and all the medicines. But if they can't pay, the hospital charges the other patients. We all pay. About $1,000 a year is paid by families now for those who have no health insurance. As more and more Americans are covered, that burden stops shifting over to those who have insurance, and that is a good thing. That hidden tax is largely ignored by the other side of the aisle, but we know it is a reality.

We also think these tax credits will make insurance more affordable. The Joint Committee on Taxation says that by 2017, these tax credits in the bill will reduce taxes by $40 billion a year for millions of Americans.

We also hear a lot said about the excise tax on insurance policies at the higher levels. That is a tax not on individuals but on the insurance companies as a disincentive to keep running up the cost of premiums and instead try to bring efficiency and cost-effectiveness into quality care.

Health reform is good for our economy too. A lot of businesses that are trying to offer health insurance find that they lose their competitive edge as the cost goes up. So as we start bringing cost down, it means more competition, more job creation, and a greater economy.

I can understand why the other side of the aisle has spent most of their time finding fault with this bill. In fact, that is part of their responsibility in the Senate. But I had hoped, at the end of the day, they would have offered their substitute, their idea on how we can truly achieve health care reform. The fact they have not reflects one of two things: It is a very tough job to do. This is a big bill, it took a lot of work, and perhaps they couldn't come up with a bill themselves. As an alternative, maybe they like the current system. They may like the health insurance companies and the way they treat Americans. They may think it is okay that the cost of premiums will continue to skyrocket beyond our reach. Most Americans disagree, and I do too.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, I ask unanimous consent to speak on time under the control of the Senator from New Jersey.

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

Mr. CARPER. Mr. President, let me follow up on some of the comments of my colleague from Illinois.

I am always struck, when I am back home—and I addressed the homebuilders in our State yesterday—by the extent of the misinformation and confusion. When I actually talk to people about the underlying legislation before us, as our deputy leader has done here again today, there is a lot to like about the legislation—a lot to like about the legislation.

One of the pieces that hasn't been focused on a whole lot and that I want to mention deals with how do we better ensure that people who are sick get well and people who are not sick don't become sick as it applies to the use of pharmaceutical medicines.

Our legislation calls for doing a number of things.

First, if people could actually be healthy, stay healthy, or get well by taking certain pharmaceuticals, we would all save money in the end. But under the current system, unfortunately, too many people in this country who would be helped by pharmaceuticals don't actually get to see a primary care doctor. We don't do a very good job in primary care in this country.

One of the things that will flow from our legislation is better access to primary care for everybody. Let me give one example of that. Currently, if you are Medicare eligible, you have one lifetime physical from Medicare. That is it, and that occurs when you sign up for Medicare. You don't get a physical every 5 years or 10 years or 20 years; you get one physical in your life that is paid for by Medicare. That will change in the legislation we will be voting on in the days ahead. We will provide annual physicals as a benefit under Medicare.

When we have more regular doctor visits from the primary care doctor, one of the things that will come about is a better understanding of the health conditions of people in this country and the notion that some of us might actually be healthier, if we have a high blood pressure reading, if we take medicine for it or if we have high cholesterol, if we take medicine for that. So the idea is to identify problems that can be treated with medicine. Not everyone can be helped but some can.

So the first key is, let's make sure folks who will benefit from having access to a primary care doctor have that access.

Secondly, if there are medicines a person can be taking that will help them, let's hope the primary care doctor will do his job, refer the patient to a specialist, if needed, in order to identify the medicines needed.

The third point would be to make sure that when those medicines are identified, they are actually prescribed and made available to the person.

As we all know, we have the Medicare prescription drug program, the Part D Program, which is a pretty good program, and about 85 percent of the people who use it actually like it. The program has been underbudget now for each of the 4 years it has been in existence. That is pretty good. But when the drug costs of a senior citizen who participates in the Medicare drug program exceed I think about $2,200 a year, instead of Medicare paying for 75 percent of the medicine and the individual paying 25 percent—which is the case from zero to about $2,200 over the course of the year—Medicare basically says: We are out of this, and so from $2,200 to $5,200, it is all on the individual unless they happen to be very low income.

So the challenge is to make sure more folks who need access to primary care get that; if they need medicines, make sure they are available, which can be determined by the doctor or doctors as to what people should be taking; No. 3, make certain people get the medicines they are prescribed, that they can afford them, and that they actually take them; No. 4, make sure that once we have the access to primary care, we have made a determination as to what medicines can be helpful to a person and that those medicines are prescribed; and then we want to make certain the person for whom they are prescribed can actually afford them. Part of that is making sure, as we are trying to do in our legislation, we take that hole, if you will, that exists from the roughly $2,200 to $5,200 and begin to fill it in so that Medicare covers more and more of the cost.

There has been an agreement with the pharmaceutical industry to cover a portion of that hole, which will take care of about half of it, and I understand from our leadership in the House and in the Senate and the President that there is a firm commitment to close it entirely. So the range from $2,200 to $5,200 per year would actually be treated just as the first $2,200 is: Medicare would cover 75 percent of the cost, and for most people, unless they are very poor, will be responsible for paying the other 25 percent. That will help a lot of people, and that will make sure folks who were doing OK taking their medicines until they hit that $2,200 gap and stopped will keep taking their medicines and they will stay out of emergency rooms and hospitals and they will be healthier as a result.

The last piece involves something new. It is called personalized medicine. I had not heard the term before, although I have been interested in the issue for a while. As it turns out, there are some medicines for certain conditions that will help one group of people—because of the way God made them, because of their genetic makeup—and there is another group of people with a different genetic makeup that will not be helped by the same medicine even though they have the same condition.

Part of what flows from our legislation will be an ever-improving ability to determine who will be helped by a particular medicine given a certain condition and who will not be, with the same condition, simply because of their genetic makeup. So the idea of making medicines available to people who will be helped, we want to do that, and we are gaining the knowledge to be able to say this group will be helped but this group will not, and we can then spend the money where it is going to make a difference but stop spending the money where it will not make a difference. We are close to being able to do that, and we need to do that.

All this flows from this legislation, and when you put it together, I think it is actually a very attractive and very smart policy.

So overall, how do we provide better health care, better outcomes for less money? There is real potential for doing it in the ways I have just described.

I want to stay on the issue of pharmaceuticals, if I can, but I want to pivot and take a somewhat different tack now.

I wrote a letter to the administration a week or so ago, maybe 2 weeks ago, and I asked the administration for some clarification on the issue of reimportation. That is the issue before us today. We have been debating it for some time, and we will be voting later today on a proposal by the Senator from North Dakota, Mr. DORGAN, and then we will be voting on an alternative to that offered by the Senator from New Jersey, Mr. LAUTENBERG, which I support. If that amendment were actually incorporated into the Dorgan amendment, I would support the underlying Dorgan amendment.

Anyway, I wrote to the administration, and I got a letter back dated December 8. I don't think I have ever stood on the floor and read a letter, but this is one I am going to read. I want my colleagues and their staff and anyone else who is listening to actually hear what I am about to say and what the administration had to say on this subject of reimportation. It is a little—well, ''awkward'' may be the wrong word, but it has to be a little awkward for the administration because the President, when he was then-Senator Obama, was a cosponsor of the Dorgan amendment. When he campaigned for Presidency, on the campaign trail he spoke favorably of the reimportation legislation offered by Senator DORGAN. Now that he is President and he leads an administration, he is asked: What is the position of your administration on that legislation you cosponsored as a Senator and spoke in favor of as a candidate? Now that you are running the country and you are the Chief Executive of the country and you have a whole Department—the Department of Health and Human Services—whose job it is to look out for our safety and health, how do you feel about it?

So I wrote a letter basically asking the question, and here is what I received in response, dated December 8. This is from the head of the FDA, the Food and Drug Administration:

Dear Senator CARPER: Thank you for your letter requesting our views on the amendment filed by Senator Dorgan to allow for the importation of prescription drugs. The administration supports a program to allow Americans to buy safe and effective drugs from other countries and included $5 million in its 2010 budget request for the Food and Drug Administration to begin working with various stakeholders to develop policy options relating to drug importation.

The letter goes on to say:

Importing non-FDA approved prescription drugs presents four potential risks to patients that must be addressed:

(1) the drug may not be safe and effective because it was not subject to a rigorous regulatory review prior to approval;

(2) the drug may not be a consistently made, high quality product because it was not manufactured in a facility that complies with appropriate good manufacturing practices;

(3) the drug may not be substitutable with the FDA-approved product because of differences in composition or manufacturing; and

(4) the drug may not be what it purports to be, because it has been contaminated or is a counterfeit due to inadequate safeguards in the supply chain.

In establishing an infrastructure for the importation of prescription drugs, there are two critical challenges in addressing these risks. First, FDA does not have clear authority over foreign supply chains. One reason the U.S. drug supply is one of the safest in the world is because it is a closed system under which all the participants are subject to FDA oversight and to strong penalties for failure to comply with U.S. law.

Second, FDA review of both the drugs and the facilities would be very costly. FDA would have to review data to determine whether or not the non-FDA approved drug is safe, effective, and substitutable with the FDA-approved version. In addition, the FDA would need to review drug facilities to determine whether or not they manufacture high quality products consistently.

The Dorgan importation amendment seeks to address these risks. It would establish an infrastructure governing the importation of qualifying drugs that are different from U.S. label drugs, by registered importers and by individuals for their personal use. The amendment also sets out registration conditions for importers and exporters as well as inspection requirements and other regulatory compliance activities, among other provisions.

We commend [''We'' being the FDA on behalf of the administration] the sponsors for their efforts to include numerous protective measures in the bill that address the inherent risks of importing foreign products and other safety concerns relating to the distribution system for drugs within the U.S. However, as currently written, the resulting structure would be logistically challenging to implement and resource intensive. In addition, there are significant safety concerns related to allowing the importation of nonbioequivalent products, and safety issues related to confusion in distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

The letter concludes by saying:

We appreciate your strong leadership on this important issue and would look forward to working with you as we continue to explore policy options to develop an avenue for the importation of safe and effective prescription drugs from other countries:

It is signed ''Sincerely, Margaret Hamburg.'' She is the Commissioner of Food and Drug.

I suspect this was not an easy letter for Ms. Hamburg to write or an easy letter for the administration to sign off on. Given the position of the President in the past on this issue and now being confronted with the actual possibility that this legislation would become law, it has to be a struggle. I commend Senator DORGAN and others who have worked with him—I think Senator SNOWE and, I believe, Senator MCCAIN—over the years to try to address the earlier criticisms of the legislation.

What the FDA says in this letter to me, and really to us, is that progress has been made. Some of the concerns have been addressed. Unfortunately, some have not been.

What I hope we do when we vote later today is accept the offer of the administration. They have been willing to put their money where their mouth is, to actually put money in their budget request to say before we go down this road as proposed in the Dorgan amendment, let's see if we can't work this out in a way that addresses some of the remaining safety and soundness concerns. I am not sure, if I were the author of the amendment, if I would have accepted that offer from maybe an earlier administration whose motives were not maybe as pure—frankly, whose Chief Executive was not committed to addressing this issue.

Our President is committed to addressing this issue. The Department of Health and Human Services and the FDA are committed to addressing this issue. They are anxious, I believe, to work it out. Not only that, they are anxious and willing to provide some of the funding needed to come to an acceptable resolution and compromise. I hope by our votes later today we will accept that offer from the administration, and I hope in the weeks and months ahead we will actually take the steps, not necessarily proposed exactly by Senator DORGAN, that will allow us to move in that direction and do so in a way that does not unduly harm or put at risk the citizens of this country.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. I understand I will be yielded time off the leader's time?

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

Mr. GREGG. Mr. President, I want to speak a little today about this issue of the tax burden the Reid bill is putting on people with incomes under $250,000, $200,000. We all know the President said he was not going to allow taxes to increase for people who have incomes under those numbers. We know there are all sorts of proposals in the Reid bill which significantly increase taxes. We also know there are a lot of proposals in the Reid bill that significantly increase fees. We also know there are a lot of proposals in the Reid bill which will significantly increase premiums—all of which people under $200,000 pay.

Why is this? Primarily it is because, if you look at the Reid bill, it exponentially increases spending and grows the size of government. Government is increased by $2.5 trillion under the Reid bill when it is fully phased in. It goes from 20 percent of our gross national product—that is what government takes out today in spending—up to about 24 percent of our gross national product, a huge increase in the size of government.

When spending increases like this, at this type of explosive rate, there are a couple of things that occur. One of them is that taxes also go up. It is like day following night. If you are going to increase the size of the government at this rate, you are going to have to significantly increase taxes—whether you call them fees or whether you call them premium increases or whether you call them outright taxes. That is what is happening. That is because the goal is to grow the government dramatically. That is the goal. When you grow the government, you inevitably increase the taxes. In fact, in this bill it is estimated, when it is fully put into place, that there will be about $1.6 or $1.7 trillion in new taxes.

There is also, when it is fully phased in, about $1 trillion of reduction in Medicare spending. We have had a lot of discussion on that matter on the Senate floor. I have been here a number of times talking about that. But the burden of taxation goes up in order to allegedly pay for these new entitlements.

Why do the taxes have to go up? Because when you increase spending this way you have to pay for it—or you should pay for it. This bill attempts to do that by raising taxes dramatically. But the presentation that you can get all this tax revenue out of people who are making more than $200,000 a year simply doesn't fly. It doesn't pass the commonsense test. It is like saying when you cut Medicare $1 trillion you are not going to affect benefits.

We heard for a week from the other side of the aisle that no Medicare benefit cuts would occur with $1 trillion of Medicare cuts. Of course, that is not true. We just heard yesterday from the Actuary—the President's Actuary, by the way, the Actuary of CMS—that when you make these significant reductions in provider payments under Medicare, which is where most of the savings occur, that means there are fewer providers who are going to be able to be profitable. In fact, 20 percent of providers will be unprofitable under the Reid bill as scored by the Actuary for CMS, and, as a result, providers will drop out of the system. Clearly, that will affect benefits to seniors because they will not be able to see providers because they will not exist anymore.

It is like telling somebody—someone said; the Senator from Nebraska, I think, said—you can have keys to the car, but there is no car. In this instance there will be no providers or many fewer providers.

Along with that problem there is this claim—along with that claim that was totally inaccurate, which is that Medicare benefits will not be cut—there is this claim that these new revenues to pay for this massive expansion in spending are going to come from just the wealthy.

Again, we have independent sources that have taken a look at this, in this case the Joint Tax Committee. They have concluded that is not the case. That is not the case at all. The argument from the other side of the aisle is we have all these tax credits in here which, when you balance them out against the tax increases, meaning that people earning under $200,000—because some will get tax credits, some will get tax increases, but they balance out so there is virtual evenness, so that the tax credits in the bill to subsidize people who do not have insurance today mostly are balanced by the tax increases on people earning under $200,000.

Of course, if you are one of the people earning under $200,000 who doesn't get the tax credit, that doesn't mean a whole lot. Your taxes are going up. But more importantly, Joint Tax has taken a look at this, and by our estimate, what Joint Tax has said is essentially this: 73 million families, or about 43 percent of all returns under the number of $200,000, people with incomes of under $200,000, will, in 2019, have their taxes go up.

So there is a tax increase in this bill, and it is very significant on people earning under $200,000. In fact, if you compare that to those people who will benefit from the tax credit, what it amounts to is for every one person who is going to benefit from the tax credit, three people earning under the income of $200,000 will see their taxes go up. That is a real problem, first, because it significantly violates the pledge of the President when he said:

> I can make a firm pledge no family making less than $250,000 will see their taxes increase—not your income taxes, not your payroll taxes, not your capital gain taxes—not any of your taxes.

That is what the President said. That pledge is violated by the Reid bill, violated very fundamentally for the 73 million people whose incomes are under $200,000 and whose taxes go up.

So it clearly is not a tax-neutral event for middle-income people. It is a tax increase event for a large number of middle-income people. Forty-three percent of all people paying taxes whose income is under $200,000 will have their taxes increased.

What is the thought process behind this? The thought process essentially seems to be we are going to explode the size of government, we are going to dramatically increase the taxes on the American people, and somehow that is going to make life better for Americans. I do not see that happening. I don't see that happening. We know from our experience as a government that growing the government in this exponential way probably is going to lead to people having a tougher time making ends meet because their tax burden is going to go up.

Discretionary dollars they might have used to send their kids to college or they might have used to buy a new house or they might have used to buy a new car or they might have just simply saved—those discretionary dollars they don't have anymore because they come to the government to fund this massive explosion in programs and this increase in the size of government.

I think we do not need to look too far to see how this model does not work. All we have to do is look at our European neighbors.

This idea that you can Europeanize the economy, that somehow if you grow the government you create prosperity, that is what is basically behind this philosophy: You grow the government, you create prosperity. That does not work. We know that does not work. All we have to do is look at our neighbors in Europe who have used that model to find out and conclude that does not work.

It would make much more sense to put in place an affordable plan, one which did not raise the taxes of 73 million people who file income taxes under the income of $200,000, 43 percent of the people paying taxes. It would make much more sense not to grow the government in this extraordinary way that we know we cannot afford and that we know ends up passing on to our kids a country which has less of a standard of living than we received from our parents.

So I hope we take another look at all the taxes in the bill, recognizing that the commitment the President made on the issue of taxes is not being fulfilled by this bill, and go back to the drawing board and reorganize it so we can come closer to what the President wanted, which was a bill that did not raise taxes; which was a bill that did insure everyone; which was a bill that did create an atmosphere where if you wanted to keep your present insurance, you could keep it; and which was a bill that turns the curve of health care costs down.

None of those four goals of the President are now met in the bill. In fact, according to his own Actuary and according to Joint Tax, for all four of those goals, just the opposite occurs. The number of people uninsured remains at 24 million people, the cost curve goes up by $235 billion, taxes go up for 73 million people, and we end up with 17 million people who have insurance today in the private sector losing that insurance. So I believe we should take another look at this bill and try to do a better job.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. FRANKEN). The Senator from Wyoming.

Mr. ENZI. Mr. President, I yield up to 20 minutes to the Senator from Alabama out of the leader time.

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SHELBY. Mr. President, I rise today in disbelief. The American public is searching for commonsense answers from its leaders on health care, and yet they are poised to receive an expensive, wholly inadequate, and simply illogical so-called solution.

After weeks behind closed doors—including now—the majority has produced a bill thus far that raises taxes, makes drastic cuts in Medicare, and increases premiums to create a new government program, the so-called public option.

I believe the public option is nothing more than socialized medicine and expanded government disguised as greater choice. Thus, I am adamantly opposed to this bill as it is written.

I believe any legislation seeking to effectively address health care reform should have as its dual aims cutting costs and increasing access to quality care. But, amazingly, this bill just does the opposite on both counts.

This proposed legislation is not going to solve our Nation's health care problems and yet likely will exacerbate them. The administration, it seems to me, seems to be determined to force the health care bill on the American people, which the majority of citizens do not want or need.

I believe we have the best health care system in the world in the United States of America. While many have scoffed at such a suggestion, the United States, as we know, has the finest doctors, first-rate treatments, cutting-edge innovation, and low wait times.

Think about it. People come from all over the world to take advantage of our revolutionary medicine and state-of-the-art treatments. The United States develops new drugs and medical devices years before the rest of the world, and American doctors are usually pioneers of new techniques in surgery and anesthesia.

As a cancer survivor myself, I am especially proud of the great strides the United States has made in screening and treating cancer. The United States has one of the highest survival rates for cancer in the world and dwarfs survival statistics in Europe. In 2007, U.S. cancer survival was 66.3 percent, while Europe's was 47.3 percent. I believe the answer as to where to receive treatment in the world is clear: the United States of America.

However, our current system, I would admit, is not perfect, and I have never said it was. But I believe we must seek to build upon rather than tear down these strengths we have. We need a bill that reduces costs and improves quality and level of care for the American people.

Here, I believe, we get the exact opposite: a bill that grows big government by creating a costly new entitlement program, drives up private health care costs, and subsequently lowers overall quality and access to care.

According to the Congressional Budget Office's Long Term Budget Outlook, the coming tsunami of Social Security, Medicare, and Medicaid costs is projected to push the Federal public debt to 320 percent of GDP by 2050 and over 750 percent by 2083.

Does anyone truly believe this new legislation will not further add to our Nation's debt? When has history proven that our government can regulate more effectively than private industry or the marketplace, much less doing so without adding to the deficit? The reason: we simply overspend and overpromise.

The Congressional Budget Office estimates that the Senate Democrats' health care proposal, as now written, will cost $849 billion over 10 years.

While Americans will be hit immediately with new taxes and government mandates, the actual services and coverage promised in this legislation will not be implemented until 2014—a clear attempt to mask the true cost of reform. The proposal before us delays government subsidies for yet an additional year to hide the real cost of the bill and show so-called additional savings.

Stalling implementation on a program set to run for an indefinite time horizon and calling it ''savings'' is nothing more than fiscal sleight of hand. Therefore, the Senate Budget Committee estimates the true 10-year cost of the proposal to be $2.5 trillion once fully implemented—$2.5 trillion once fully implemented. Let me say that again: $2.5 trillion—a lot of money.

To pay for this $2.5 trillion worth of legislation, the government, I believe, will have no choice but to raise taxes to European welfare state levels or impose drastic restrictions on patient care or, most likely, both.

The bill includes over $493 billion in new tax increases, as written, and probably another $464 billion in Medicare cuts, placing the burden of reform squarely on the shoulders of the middle class, small businesses, and the elderly.

For the middle class, the proposal is a direct hit. The Joint Committee on Taxation estimates that in 2019, 73 percent of the so-called wealthy taxpayers paying the proposed excise tax on high premiums will earn less than $200,000 a year. I think the time is now to stop heaping debt obligations on the backs of the able bodied.

The proposed tax on the so-called Cadillac plans—plans with high annual premiums—will not only be passed on to the consumer through higher premiums but will creep its way into the lives of many middle-class Americans.

I have a little story. Mrs. Melanie Howard, of Pelham, AL, raised this point when discussing the idea of who actually receives Cadillac health care. Mrs. Howard spoke to me of the small nonprofit where she worked, which had to raise premium prices to offset a few workers who were battling cancer. In effect, she was paying for a Cadillac but still just getting a basic car. Because the tax is based on cost of coverage and not quality and breadth of coverage, many Americans could fall into this category.

I believe it is a simple actuarial fact that smaller risk pools result in higher premiums. Thus, small businesses, such as Mrs. Howard's employer, are naturally going to bear the brunt of this ill-conceived Cadillac health insurance tax.

As taxes increase to pay for the public option, so does the cost of premiums on health care plans. The Congressional Budget Office analysis on premium impacts estimates that family premiums would increase 28 percent—from $11,000 per family to over $14,000 per family by 2019. This is more than a $3,000 increase per family.

The bill also imposes $28 billion in new taxes on employers who do not provide government-approved health plans, and it charges a penalty of $750 per uninsured individual—a form of double taxation.

Furthermore, any opportunity to allow individuals to self-manage their care and plan for future health care costs has been eradicated from this proposal as now written. Flexible spending accounts help individuals and families pay for out-of-pocket medical expenses that are not covered by their health insurance plans with tax-free dollars. These are particularly important for individuals and families who have high medical expenses, such as seniors and those with chronic health conditions or disabilities.

The current proposal before us will not only limit allowable flexible spending account contributions, but the limit is not indexed for inflation, which means the inflation-adjusted or real value of a flexible spending account will decline steadily over time until virtually worthless.

What is also truly concerning about the current legislation is a massive reduction in care our seniors will face under this legislation. The proposal includes $120 billion in cuts to Medicare Advantage, nearly $135 billion in Medicare cuts for hospitals that care for seniors, more than $42 billion in cuts from home health agencies, and nearly $8 billion in cuts from hospices, of all places. I believe this nearly $½ trillion in Medicare reductions simply must result—has to result—in vast reductions in the quality of our seniors' care.

I do not believe massive tax increases, a rise in the cost of health care premiums, reduced flexibility in self-management of care, and cuts to seniors' health care is what the American people have in mind as a way to improve access and create affordable quality health care.

We have already seen how this legislation will significantly increase costs and reduce coverage of care. But let's, for a minute, turn our attention to the quality of care because there is, indeed, a big difference between government-run health care coverage and actual access to medical care.

As Margaret Thatcher once said:

> The problem with socialism is that eventually you run out of other people's money to spend.

Medical rationing is inevitable under government-run health care. It has to be. Supporters of government-run medicine often cite Canada or Great Britain as models for the United States to follow. Yet medical rationing, such as is common in those countries, is inevitable under a government-run health care system as now proposed. These countries are forced to ration care or, in the alternative, have long waiting lists for medical treatments that lead to the same result.

More than 750,000 Britons are currently awaiting admission to the National Health Service hospitals. Last year, over half of Britons were forced to wait more than 18 weeks for care or treatment. The Fraser Institute, an independent Canadian research organization, reported in 2008 that the average wait time for a Canadian awaiting surgery or other medical treatment was 17 weeks, an increase of 86 percent since 1983.

Access to a waiting list is not access to health care.

A study by the Organization for Economic Co-Operation and Development showed that the number of CT scanners per million in population was 7.5 in Britain, 11.2 in Canada, and 32.2 in the United States.

For magnetic resonance imaging—MRIs—there was an average of 5.4 MRI machines per million in population in Britain, 5.5 in Canada, and 26.6 in the United States.

Government-run health care will undermine patients' choice of care.

Citizens in those countries are told by government bureaucrats what health care treatments they are eligible to receive and when they can receive them. I believe Americans need to understand that all countries with socialized medicine ration health care by forcing their citizens to wait in lines to receive scarce treatments. Simply put, government financing means government control, and government control means less personal freedom.

While we need to enact reforms to our health care system that will reduce cost and improve access, our Nation cannot withstand the deep deficits this colossal health care entitlement program, I believe, would create. Instead, we need a system that restores the patients and doctors as the center of every health care decision, rather than the government and insurance companies.

By making insurance portable, expanding health care savings accounts, reducing frivolous lawsuits, emphasizing preventive care, reducing administrative costs, and making insurance

more affordable to small business and individuals, I believe we can efficiently decrease the costs that currently burden Americans while expanding coverage. The result would be improved quality and affordable care.

It appears that no matter how many thousands of letters my office receives in the Senate asking Congress to stop this legislation, this administration is determined to pass something—anything—no matter what the cost or how damaging the result. The latest CNN poll shows 64 percent of Americans oppose this health care reform as now written. The Associated Press reports that over 60 percent of Americans are against this type of reform.

It has been said we would be committing Senatorial malpractice to pass legislation such as this. I agree. I simply do not believe the American people desire or deserve what government-run health care would result in: higher taxes, larger deficits, and rationed lower quality care.

While we need to enact reforms to our health care system that will reduce costs and improve access to all Americans, our Nation cannot withstand the massive cost this colossal health care entitlement program will create.

The health of this Nation will not be helped by risking our Nation's financial well-being. It has been said if you think health care is expensive now, wait until it is free.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

AMENDMENT NO. 2793

Mr. DORGAN. Mr. President, I yield myself such time as I may consume under the hour I control.

We are going to have people trotting onto the floor of the Senate this afternoon—and some have this morning—talking about this issue of prescription drug reimportation and saying there are safety problems with it—safety problems. I wish to talk about one small piece of health care reform without which you can't call it health care reform, because at least with respect to the issue of pricing of prescription drugs, there will be no reform unless my amendment is passed.

My amendment is bipartisan. It includes support from Senator SNOWE, Senator MCCAIN, Senator GRASSLEY on that side and many Democratic Senators as well and it says: Let's put the brakes on these unbelievable increases in the price of prescription drugs; a 9-percent increase this year alone in brand-name prescription drugs.

Why is this an important issue? How about let's talk about the price of Nexium—the price of Nexium. You buy it, if you need it: $424 for an equivalent quantity in the United States. If you want to buy it elsewhere, not $424; you pay $37 in Germany, $36 in Spain, $41 in Great Britain. We are charged the highest prices in the world for prescription drugs.

We are going to have a lot of people come out and say: Well, there will be safety problems if we reimport FDA-approved drugs from other countries—absolute rubbish.

Here is Dr. Rost, a former vice president for marketing for Pfizer Corporation, and this is what he said:

> During my time I was responsible for a region in northern Europe. I never once—not once—heard the drug industry, regulatory agencies, the government, or anyone else saying that this practice was unsafe. Personally, I think it is outright derogatory to claim that Americans would not be able to handle reimportation of drugs when the rest of the educated world can do it.

They have been doing this in Europe for 20 years, reimporting lower priced prescription drugs from other countries, and they do it safely. Our consumers pay the highest prices in the world because there is no competition for prescription drugs. When a drug is sold for a fraction of the price elsewhere—one-tenth the price for Nexium in Germany and Great Britain—the American people can't access it. Even though it is made in the same plant, the same pill put in the same bottle, the American people are told: It is off-limits to you.

Dr. Rost also said this: Right now, drug companies are testifying that imported drugs are unsafe. Nothing could be further from the truth. This from a former executive of Pfizer Corporation.

When the pharmaceutical industry goes around the Hill today and tells you that importing medicine is going to be unsafe—and by the way, our bill only allows the importation from Australia, New Zealand, Japan, and the European countries, where they have an identical chain of custody and where we require pedigree and we require batch lots that will make the entire drug supply much safer, including the domestic drug supply—when the pharmaceutical industry goes around the Hill today saying: If you vote for the Dorgan-Snowe-McCain, et al. amendment, you are voting for less safety, ask the pharmaceutical industry this: What about the fact that you get 40 percent of your active ingredients for drugs from India and China and from places in India and China in many circumstances that have never been investigated or inspected by anyone? Answer that, and then tell us that reimporting FDA-approved prescription drugs from other countries is unsafe. What a bunch of rubbish.

My understanding is, sometime yesterday—maybe late last night—somebody made a deal. I don't know what the deal is, but I guess the deal is to say we are going to have this amendment—it has been 7 days since we started debating this amendment—we are going to have this amendment vote and then we are going to have another vote on another amendment that nullifies it. It is the amendment I call: I stand up for the American people paying the highest prices in the world for prescription drugs.

If you want to support that amendment, go right ahead. What you are doing is nullifying any ability of the American people to have the freedom to access lower priced drugs where they are sold elsewhere in the world. I am talking about FDA-approved drugs made in FDA-approved plants. It doesn't matter what the fancy wrapping and the bright ribbons are on this package.

This package to nullify what we are trying to do is a package that comes directly from the pharmaceutical industry. Why? To protect their interests. This year they will sell $290 billion worth of drugs, 80 percent brand-name prescription drugs. On brand-name drugs, the price increased 9 percent this year and on generic drugs it fell by 9 percent. Now I understand why they want to protect those interests.

Here are two pill bottles, both contain Lipitor, both made in a plant in Ireland by an American corporation. This sent to Canada, this sent to the United States. The American consumer gets the same pill made in the same bottle made in the same plant by the same company. The American consumer also gets the privilege of paying nearly triple the price and can't do a thing about it because this Congress, vote after vote after vote, has said: We stand with the pharmaceutical industry and against competition and against freedom for the American worker.

If I sound a bit sick and tired of it, I am. We have been going after this for 8 to 10 years, to give the American people the freedom to access the identical FDA-approved drugs for a fraction of the price where they are sold everywhere else in the world, and we are told again and again and again there is this phony excuse about safety, completely phony.

I will have more to say about it later, but I did want to say we are going to see a lot of people trotting out here with such a shop-worn, tired, pathetic argument to try to keep things as they are and try to keep saying to the American people: You pay the highest prices in the world for brand-name drugs and that is OK. That is the way we are going to leave it. We will call it health care reform, and at the end of the day, that is what you end up with: The highest prices in the world, a 9-percent increase just this year alone. Over the next 10 years, that 9-percent increase, just this year, nets the pharmaceutical industry $220 billion, but that is OK. That is the way you are going to end up, American consumer, because we don't want to give you the freedom to access those lower priced drugs where they are sold for a fraction of the price.

One final point. I have mentioned often an old codger who sat on a straw bale at a farm once where I had a meeting, and he said: I am 80 years old. Every 3 months we have to drive to Canada across the border because my wife has been fighting breast cancer. Why do we drive to Canada? To buy Tamoxifen. Why do we have to go there to buy it? We paid—I think he said—

one-tenth the price in Canada. We couldn't have afforded it otherwise.

Is that what we want the American people to have to do? Most people can't drive across the border someplace. Why not establish a system like they have had in Europe for 20 years, to allow the American people the freedom to access reasonably priced drugs, FDA-approved drugs.

So this is a day in which we will vote on my amendment and then we will vote on an amendment that nullifies it and we will see whether enough of a deal has been made so the fix is in. So, once again, the American people end this day having to pay the highest prices in the world. Pay, pay, pay, pay, soak the American consumer, keep doing it. That has been the message here for 10 years.

A group of us, Republicans and Democrats, 30 who have cosponsored this legislation, have said, you know what. We are sick and tired of it. Give the American people the freedom. If this is a global economy, how about a global economy for real people? How about let them have the advantages of a global economy?

Once again, I will have a lot more to say this afternoon. It is apparently a day for deal-making and we will see who made what deals, but we are going to have votes. I know one thing. I know the pharmaceutical industry has a lot of clout. I know that. I hope the American people have the ability to expect some clout on their behalf in the Chamber of the Senate this afternoon.

I yield the floor, and I make a point of order that a quorum is not present.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. DORGAN. Mr. President, my understanding is there is a desire by some to have a quorum call in which the quorum call time is charged against all sides. My understanding is, there are, I think, 5 hours allocated with respect to today: 1 hour for the Baucus amendment, 1 hour for the Crapo amendment, and 3 hours distributed as follows: 1 hour for me, 1 more Mr. LAUTENBERG, and 1 hour for the Republican leader on the prescription drug reimportation; am I correct?

The PRESIDING OFFICER. That is correct.

Mr. DORGAN. So I ask unanimous consent that the quorum call be allocated against the 4 hours and not against the hour I control.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. Reserving the right to object, we have had constant speakers over here, so we have used a lot of our time. If we had known there was more vacant time, and if we could have had some of the majority's time, we could have had a steady stream of speakers over here the whole time. So we would reluctantly agree to the time being divided between the two sides, as we have done that in all the times in the past, but we want to reserve some time for our speakers as well. We could have easily had people over here to speak.

Mr. DORGAN. Well, Mr. President, did the Senator object?

The PRESIDING OFFICER. I think he reserved his right to object.

Does the Senator object?

Mr. ENZI. Yes, the Senator objects.

The PRESIDING OFFICER. Objection is heard.

Mr. DORGAN. Mr. President, my understanding is I will put in a quorum call, the time is equally divided, apparently, between the sides, in a circumstance where the other side has 3 hours and our side has 2 hours and especially on the subject I have just discussed, the other side has 2 hours and I have 1 hour.

I will put us into a quorum call, and I guess it will be equally divided between the two sides.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. CARPER). Is there objection?

Without objection, it is so ordered.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. KYL. Mr. President, I want to speak in favor of the Crapo motion, which we will be voting on in a few hours.

The Crapo motion would essentially protect the American middle class from tax increases in this bill. The President promised that nobody making under $200,000 a year, or families making under $250,000 a year, would see tax increases under the bill. But they do.

The Crapo motion would simply send the bill back to the Finance Committee and make sure that they don't. It is a fairly straightforward amendment, and we should support it.

In supporting the motion, I will discuss other things related to it. There is this notion that somehow or other the health care bill will save money for the government and for taxpayers and patients. That is where it is wrong. That is why we need things such as the Crapo motion.

How does the expenditure of trillions of dollars in new spending save anybody money? That is counterintuitive. The answer is, of course, that it doesn't.

Jeffrey Flier, dean of the Harvard Medical School, gives this bill a failing grade. He wrote in the Wall Street Journal:

> The Democrats' health care bill wouldn't control the growth of costs or raise the quality of care.

I think that is the fact. So let me point out a couple of the bill's provisions that undermine this savings argument, one of which is the new taxes, which the Crapo motion would explicitly address, The new subsidies that fail to address costs, and finally this inclusion of the CLASS Act, which is a massive new expenditure and entitlement that would grow out of control over time.

First, though, let me focus on these new taxes, 12 in total. They go into effect immediately. In fact, the Internal Revenue Service estimates it would need between $5 billion and $10 billion over the next 10 years just to oversee the collection of these new taxes. Think about that.

These new taxes include, but are not limited to, a new payroll tax on small businesses. What better way to kill job creation. We will impose another ½ percent tax if you hire somebody or all the people you retain on the payroll. That is crazy at a time when we are trying to create new jobs. There is a tax on seniors and the chronically ill. I discussed that yesterday. There are new limits on health savings accounts which will increase taxable income for middle-class families, and a new medical device tax which will be paid for by American families, according to the Congressional Budget Office. In other words, if you need a health or life-saving device, such as a diabetes pump or stent for your heart, why do you want to tax that if it provides better health care for you and your family? The reason is they need more revenue to pay for the expenses of the bill. They increase the taxes. CBO says they will be passed right through to the patients which are then passed through in the form of higher premium costs.

As I said, most of these taxes would start immediately and many would hit middle-income families despite the President's famous campaign pledge.

Washington, for a period of 4 years, piles up the money before it pays any of the money out. That is supposed to lower costs because for the first 4 years there are not any expenses. We are collecting all this revenue and somehow or another that is portrayed as a savings for the Federal Government.

Over the next 10 years that money is spent out, it is $2.5 trillion in spending, and that is not sustainable. This is part of the bill's gimmickry to create this idea that somehow the bill is deficit neutral. As I said, when you take a look at the true 10-year cost beginning in 2014 once the bill is fully implemented, you have a whopping $2.5 trillion pricetag.

Colleagues on the other side say: It is necessary to raise all this money to subsidize the increased cost of health care. I get it. We are going to raise premiums under the bill and then we are going to need to raise taxes to subsidize so people can afford those increased premiums. What sense does that make? I ask, do Americans want to pay more taxes in order to get a subsidy because of the increase in costs that are the result of this legislation?

Would they rather not have the premiums go up in the first place, as the ideas that Republicans have proposed would ensure? But that is what the bill does. It raises premiums so then you have to raise taxes to subsidize the cost of insurance.

What the Crapo motion would do is to say the President needs to keep his promise. Those making less than $200,000 a year should be relieved of this tax burden.

Secondly, if the government subsidizes insurance for 30 million more Americans, obviously costs have to rise. As the respected columnist Robert Samuelson wrote in a recent Washington Post column—by the way, the title was ''The Savings Mirage on Health Care'':

> The logic is simple. . . . Greater demand will press on limited supply; prices will increase. The best policy: Control spending first, then expand coverage.

That is what Republicans have been proposing. We would like to target specific solutions to the problems of cost which would then allow more Americans to gain access to affordable health care and, thus, avoid a hugely expensive Washington takeover of the entire system.

Our solution includes medical liability reform—that does not cost anything; it saves money—allowing Americans to purchase insurance policies across State lines, allowing small businesses to pool their risks and purchase insurance at the same rates corporations do. These solutions would bring down costs and, at the same time, enhance accessibility.

Third—and the reason I raise this is because several colleagues on the other side of the aisle have made pretty firm statements about not being able to support this legislation as long as it included what is called the CLASS Act. This is a new government-run, government-funded program for long-term care. It is intended to compete with private insurers' long-term care plans. Notice the pattern of government wanting to compete with private entities. That is what the CLASS Act does.

Participants would pay into this new government system for 5 years before they would be allowed to collect any benefits. Naturally, you have some increased revenues for a while, and that is what the bill counts on in order to allegedly be in balance. Of course, the payouts occur later, and then it is not in balance. Participants would have to be active workers. So this new entitlement would not benefit either seniors or the disabled.

We are talking about a brandnew entitlement. If a worker begins making payments in 2011, he or she could not collect benefits until the year 2016. That is why supporters of the CLASS Act say this would reduce the deficits in between 2010 and 2019. Sure, if you don't spend money in those years and you collect a lot of tax revenues, of course you are going to have more of a surplus of revenues. What happens, though, when the claims on that money occur? It is like Medicare today: It is very soon out of money and then broke and then in a hole and then you have a big debt on your hands. That is precisely what happens here. No government program has ever reduced budget deficits, we know that.

The Congressional Budget Office confirms that this program will, indeed, add—add—to future budget deficits. Here is what the CBO writes:

> The program would add to future federal budget deficits in large and growing fashion.

It does not get any simpler than that. The CLASS Act would add to future deficits. That is why several of my colleagues on the other side of the aisle have said they cannot support the bill as long as the CLASS Act is in it. But the last time I checked, it is still in it.

I want to also refer to the chairman of the Budget Committee who has obviously spoken out on this issue because he understands the effect. I speak of Senator CONRAD. He said it is like a Ponzi scheme because it offers returns that payments made into the system cannot cover in the long run.

As I said, it would generate generous surpluses for the government while Americans pay in and are not collecting benefits. And then later on, it reaches a point where payments made into the program cannot sustain the promised benefits.

Here is what CBO tells us about the program:

> It would lead to net outlays when benefits exceed premiums. . . .

''Net outlays'' means you are spending more than you are taking in.

> [By 2030] the net increase in federal outlays is estimated to be ''on the order of tens of billions of dollars for each [succeeding] ten-year period.''

Over time, this program adds substantially to the deficit and to the debt. It is an entitlement that is not self-sustaining but has to be propped up in some fashion by additional revenues. It is another way, in addition to the first two ways I mentioned, of how costs go up in this legislation, how savings do not result, and how the American public has to end up making up the difference. You have new taxes to cover subsidies for increased premiums, government subsidies for 30 million Americans that increased demand without addressing costs, and finally, the inclusion of the CLASS Act.

As I said, I support the Crapo motion because it would assure that none of these burdensome new taxes would hit middle-income families as they are set to do. This amendment must pass if President Obama is going to keep his campaign pledge to not raise taxes ''one dime'' on middle-income Americans.

I also support the soon-to-be-pending Hutchison-Thune motion which says that no taxes at all should be levied until Americans see some benefits. This addresses that problem I noted where you collect the taxes up front and then you start paying benefits at a later date. This is an expression of disapproval for the budget gimmickry contained in the bill.

Americans want us to bring costs down. They could not be more clear about that. But the provisions of this bill disobey the wishes of the American people. That is why in public opinion surveys—it does not matter who takes them—they are increasingly showing that the American people are opposed to this legislation. The latest one by CNN just a few days ago—and CNN is not noted to be a big conservative organization—shows that 61 percent of the American public oppose the health care plan. And now only 36 percent support it. That is getting close to two to one in opposition.

An earlier poll showed that among Independent voters, by more than three to one, they oppose what is in this legislation. The point here is not some peripheral issue—and I do not mean to demean the importance of the issue when I talk about, for example, the public option for the government-run insurance plan. The abortion language certainly is a key issue to many. Even if you could somehow fix those problems, you still have the core of the bill that the American people object to: the $½ trillion in cuts in Medicare, the $½ trillion in increases in taxes that are meant to be addressed by the motion I am speaking of, the requirement that because premiums go up under the legislation, you have to raise taxes to create a subsidy so you can give it to people so they can afford the increased premiums.

Something we are going to be talking about in the future and have hardly addressed but to me is probably the most pernicious thing of all—you can talk about the government takeover, you can talk about the additions to the debt, the taxes, the increased premiums, all of these things, the cuts in Medicare—to me the most pernicious thing of all is the fact that it is unsustainable. The promises exceed the revenues with the net result that over time, care will have to be rationed.

This is what I think the American people fear most of all because they know you cannot sustain a program this costly and not have to at some point begin to delay care, delay appointments so they do not occur as rapidly and gradually begin to denying care. That is why this big kerfuffle about the commission that made recommendations on breast cancer screening and mammograms was so frightening to people. They could see this was the way rationing begins. Some panel says we don't think people need as much medical care as they have been getting, never mind what has been recommended in the past. Yes, by the way, it will save money.

Of course, when politicians have to find a way to reduce benefits, they do not go to their constituents and say: We are going to cut your benefits. What they do is reduce the payments to people who provide the health care—

the doctors, hospitals, home health care, hospice care, these folks. They reduce payments so that the providers have no choice but to reduce the amount of their care.

They have to see more patients, there are not as many of them, and they are getting paid less. So naturally they cannot provide the same level and quality of care. That is how rationing begins. Ask people in Canada, ask people in Great Britain how long it takes to get in to see the doctor. Eventually even that does not cut it. So they set a budget and say: We cannot afford to pay any more than that.

You better hope you get sick early in the year. That is, unfortunately, what you can see to an extent in our veterans care but even more in our care for our Native Americans. I did not make this up. Others have said in the Indian Health Care Service, get sick early in the year because they run out of money if you get sick late in the year.

Our first obligation ought to be to ensure our Native American population receives the care we have promised them. I personally have gone throughout Indian reservations in Arizona. We have more than any other State. I made a tour of the Navajo reservations, including a lot of the health care clinics and facilities that try to take care of folks under the Indian Health Service. None has enough money to do what they are supposed to. They are understaffed. The people who are there are wonderful, dedicated health care providers. They are doing their best. But you ask any of the Native Americans whether they believe they are getting the care they are supposed to get under the program, and the answer is uniformly no. They have to wait forever. The care is not there when they need it.

This is the perfect example of rationing of care, what happens when you have a government-run system. That is what I fear most of all will result from this because we have taken on much more than we can afford.

The end result of that inevitably is the reduction in the amount of care that is provided and the quality of care that is provided.

I urge my colleagues to think very carefully about what we are getting our constituents into. We can start to turn this back by supporting the Crapo motion which at least says that folks who are middle-class families, who the President promised would not see a tax increase, will not see a tax increase under the legislation. That is what the Crapo motion would provide, and I certainly hope my colleagues support it.

RECESS

Mr. KYL. Mr. President, if there are no other Senators seeking recognition at this time, I ask that the Senate stand in recess under the previous order.

Thereupon, the Senate, at 12:45 p.m., recessed until 3:16 p.m. and reassembled when called to order by the Presiding Officer (Mr. CRAPO).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—Resumed

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. VITTER. Mr. President, I rise to strongly support and urge all of my colleagues, Republicans and Democrats, to support the upcoming Dorgan reimportation amendment which we will be voting on later today and, just as important, to oppose the Lautenberg amendment which, as everyone knows, is a poison pill to reimportation and is simply and surely a way to absolutely kill for all practical purposes the real Dorgan reimportation language.

To me, this is a crystal-clear choice, and it is the sort of choice the American people are really interested in and really watching. It is a choice between doing something that can make a difference in people's lives, something that can help people, that can solve a real problem in health care by doing something in a focused way or we can choose to keep to the big political deal that was made inside the beltway, inside the White House with the pharmaceutical industry. That is the choice. This is really a choice between voting for the American people or voting for politics as usual in Washington. That is what it all comes down to.

On the positive side, reimportation is a very real and very effective solution to a real problem. The problem is obvious. The problem is sky-high prescription drug prices—the highest in the world—that we as Americans pay. These same drugs are sold around the world, and in many different cases—in virtually every case—we pay the highest prices in the world right here in the United States even though we have the biggest marketplace for prescription drugs. That is the system we are trying to break up. So I want and supporters of this amendment want a true free market in prescription drugs, a world price that will lower the U.S. price and dramatically help U.S. consumers.

It is not just supporters of this amendment and this concept who are making these arguments; it is unbiased sources such as the Congressional Budget Office and others. The Congressional Budget Office says this amendment—this reimportation concept will save the Federal Government money, significant money, some $18 billion or more. And besides the savings to the Federal Government, the savings to the U.S. consumer are much greater—$80 billion or more.

So that is the positive choice—doing something real about a real problem. That is what the American people want us to do. They want us to focus on the real problems that exist in health care and attack those real problems in a focused way.

The other alternative is to keep the political deal, to vote yes for politics as usual in Washington. Tragically, that is what is represented by the political deal that was struck on this global health care bill between the White House and the White House's allies here in the Senate and the big pharmaceutical industry. It has been widely reported—it is no secret—that there was a deal between these bodies. The pharmaceutical industry agreed to support the President's initiative, putting as much as $150 million of TV advertising cash behind that support, if the White House would completely change its position on reimportation and other key points.

The record is clear: When President Obama served right here with us in the U.S. Senate, he was completely for reimportation. As a Presidential candidate, he campaigned vigorously for reimportation. Rahm Emanuel, the White House Chief of Staff, when he served in the U.S. House, was strongly for reimportation. But now, all that is off because Washington politics as usual has stepped in the way. They have reversed their position through this deal with PhRMA. Tragically, that has crept into the Senate Chamber as well. Key Senators on the Democratic side—MAX BAUCUS and JAY ROCKEFELLER and others—have reversed their position and apparently now are urging ''no'' votes for a policy they have long supported.

Well, we will know in a few hours who will be the winner—the American people, being given lower prescription prices, or PhRMA and politics as usual in Washington. Make no mistake about it, that is the choice. It couldn't be laid out in a clearer way. And to choose for the American people, to make real progress for lower prescription drug prices, we need to do not one but two things: first, to pass the Dorgan amendment, and second, and just as important, to defeat the Lautenberg amendment side-by-side, which would clearly, by all acknowledged sources, be a poison pill to reimportation—an easy way for the administration to ensure reimportation never happens.

I urge all of my colleagues, Democrats and Republicans, to vote for lower prescription drug prices, to vote for the American people, and certainly to vote against Washington politics as usual, which the American people are so completely disgusted and fed up with. I urge that vote. Americans all around the country, in all our home States, will remember it and will thank us for it because we will actually be providing a real solution to a real problem and bringing them significantly lower prescription drug prices.

With that, Mr. President, I yield the floor, and 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. CRAPO. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. UDALL of Colorado). Without objection, it is so ordered.

Mr. CRAPO. Mr. President, I believe I have 20 minutes remaining; is that correct?

The PRESIDING OFFICER. The Senator from Idaho has 17½ minutes remaining.

Mr. CRAPO. Mr. President, I ask that the Chair notify me when I have 2 minutes remaining.

The PRESIDING OFFICER. The Chair will so notify.

Mr. CRAPO. Later today, Mr. President, we are going to vote on my motion to refer the bill to the Finance Committee and have the Finance Committee simply make the bill comply with the President's promise with regard to taxes.

As I have said a number of times on the floor, this bill does not correct so many of the problems we need to deal with in health care. It drives the cost of health care in premiums up, not down; it raises hundreds of billions in taxes; it cuts Medicare by hundreds of billions of dollars; it grows the Federal Government by over $2.5 trillion in the first 10 years of full implementation; it forces the needy uninsured into a failing Medicaid system and does not give them access to insurance; it imposes damaging unfunded mandates on our struggling States; it still leaves millions of Americans uninsured; and it establishes massive government control over our health care. Frankly, even if the so-called government option or government health care insurance company that is created by the bill were to be removed, there would still be massive government intrusion into the control and management of our health care system.

Well, as we were facing the prospect of dealing with this bill, the President made a pledge to the American people, and in his terms the pledge was:

> I can make a firm pledge, no family making less than $250,000 will see their taxes increase; not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes. You will not see any of your taxes increased one single dime.

Yet what we have in this legislation is a whole array of new taxes—about $493 billion in new taxes to start with. And that is assuming you just start with the beginning of the bill and go for the first 10 years. If you actually compare the number of taxes that will be charged by this bill to the American people with that first full 10-year implementation period, that is $1.28 trillion in new taxes.

This chart shows taxes and fees, not just the specific taxes but taxes and fees—fees which our Congressional Budget Office and our Joint Tax Committee have said repeatedly will be passed on to the American consumer. Yet the President said nobody's taxes will be increased.

Let's see the next chart. Here we have further analysis of just four of the major tax provisions in the bill. There are many more, but if you look at the four major tax provisions in the bill, the Joint Committee on Taxation has said that by 2019 at least 73 million American households earning below $200,000 will face a tax increase, and when you break these numbers down further, it is not just the people making between $100,000 and $200,000, or the upper income earners, but massive tax increases falling upon people who are making well under $100,000 a year.

The response has been: Wait a minute, this bill also has some tax cuts in it, and when you offset the tax cuts against the tax increases, there are more tax cuts than there are tax increases.

I dispute that in a couple ways. First of all, even if you accept as fact that there are tax cuts in this bill, which is arguable and I will point that out in a minute, they do not offset all the taxes and fees, so it is still a net increase in taxes. But there is a subsidy in this bill to provide insurance to a group of Americans who do not have the financial capacity today to purchase their own insurance. As I mentioned earlier, the most needy of this group did not get access to insurance. They got put on Medicaid. But some in America will get some access to insurance and that subsidy will be provided by the Federal Government. The other side is saying that is a tax cut.

I disagree with that for a couple reasons. First of all, it is called, in the bill, a refundable tax credit and it is administered by the Internal Revenue Service—which, by the way, is going to need to grow by 40 to 50 percent in order to accommodate these new roles in managing the health care system. But it is a refundable tax credit in only the way Congress could put it together. It is nothing other than a government payment to individuals, most of whom pay no taxes. In fact, between 2014 and 2019, 73 percent of the people receiving the subsidy, or $288 billion of the subsidy, goes to taxpayers who pay no taxes. You can call that a tax cut if you want, but CBO, our Congressional Budget Office, does not call it a tax cut. The Congressional Budget Office scores it as Federal spending, as exactly what it is, spending by the Federal Government. It is a subsidy being provided by the Federal Government. You can argue about whether it should be provided, but to call it a tax cut is a stretch.

Even if you accept that is a tax cut, there are still 42 million American households earning below $200,000 per year who will pay more taxes. No matter how you cut it and no matter how you define tax cut, the reality is this bill imposes hundreds and hundreds of billions of dollars of new taxes squarely on the middle class in violation of the President's promise that nobody in America who makes less than $250,000 as a family or $200,000 as an individual, in order to fund this bill, would be required to pay more taxes.

Some of those who have responded to this have said this is our opportunity and, if we support this amendment, we will be killing a bill that provides tax relief to the American people. As I have pointed out, the amendment does not do anything to the subsidy that is called a tax cut. The amendment leaves the subsidy in place. So it is simply wrong to say the motion I have asked to have passed would do anything to remove this so-called tax relief—or properly called subsidy—from the bill. What my motion does is simply to say the bill should be referred to the Finance Committee so the Finance Committee can make sure it complies with the President's pledge that it does not raise taxes on those who are in what the President has described as the middle class. It is very simple and straightforward. If there are no such taxes, then the motion is irrelevant. But we all know there are—Joint Tax, Congressional Budget Office, many private organizations have squarely pointed it out. In fact, we are still studying it. If we get past the first four big taxes in the bill, these numbers I have talked about, the 42 million net or the 73 million in reality, in America—and those are households, not individuals, who will be paying more taxes—are squarely going to be hit by this bill.

Let me give a different perspective on it. If you take all those who are supposedly getting tax relief but are really getting a direct subsidy, accept the fact that this is truly a tax cut, they represent 7 percent of the American public. The rest of the American public does not get a subsidy. The rest of the American public pays the taxes for the establishment of a huge $2.5 trillion new entitlement program that will bring that much more of the Federal Government into control of the health care economy.

We are coming back now from a 2½-hour break because the Democrats were at the White House meeting with the President. We do not know what was said there. There was apparently a negotiation behind closed doors, yet once again, of some other new changes in the legislation, some other new portions of the bill. No C–SPAN cameras were there, to my knowledge. But we now have an opportunity to talk in the next few hours about what will happen with regard to this amendment.

The President could have asked his friends in the Democratic caucus to support this amendment, which simply requires that the bill comply with his pledge. I hope he did. I hope it can be accepted. But the reality is, this legislation violates not only this pledge but a number of the President's other pledges—for example, the pledge that if you like what you have, you can keep it. Americans all over this country have heard that pledge repeated a number of times. If you are one of the employees who has employer-provided insurance and that insurance happens to fit in the so-called higher insurance packages that are taxed 45 percent by this plan, you are not going to get to keep it. Both CBO and Joint Tax have

made it very clear that you are going to see your health care cut by your employer in order to avoid this tax. Then what is going to happen is your employer might—probably will—give you a little bit more wages to compensate for the cut in your employment benefits. Your net package of compensation will not change in value, but you will get at more of it in wages and a little less in health care. But the kicker is, the wage portion is taxed but the health portion is not so your taxes are going to go up and your net package is going to go down. You are going to have a less-robust health care plan and you will have a lower overall compensation package. Does that comply with the President's promise that if you like what you have, you can keep it? What about the 11 million Americans, I believe it is, who have Medicare Advantage policies today who clearly are going to lose about half of that extra Medicare Advantage benefit under the Medicare cuts in the bill? If they like what they have, can they keep it? No.

What I am asking is simply that the Senate vote to require that the President's pledge in this one case be honored; namely, let's send the bill to the Finance Committee, it can be turned around in the Finance Committee overnight, take out the provisions that impose taxes on people in America earning less than $250,000 as a family or $200,000 as an individual and bring it back to the floor.

You will hear it said this is a killer amendment, that it will kill the bill. It will not kill the bill unless it is necessary in the bill to tax Americans to the tune of the hundreds of billions of dollars that are included in this bill. What it will do is expose that this bill cannot be claimed to be deficit neutral or to even reduce the deficit unless three things happen: the Medicare cuts of hundreds of billions of dollars are imposed; the tax increases of hundreds of billions of dollars are imposed, and the budget gimmicks are implemented.

Let me tell you about the most significant of those budget gimmicks. In order to make it so they could say this bill does not increase taxes or does not increase the deficit, the crafters of the bill have had the taxes go into effect on day one, the Medicare cuts go into effect by day one, but the subsidy program or the spending part of the bill is delayed for 4 years. So we have 10 years of revenue and 6 years of spending.

I, personally, think the way they picked 2014 to be the year in which they implement the spending part of the bill is they said: How many years do we have to delay the spending impact until we can claim there is a deficit-neutral bill? It turned out they had to delay it for 4 years out of the 10. If it took 5, they would have delayed it 5 years. That is a budget gimmick. The reality is we all know if you have the spending go into place on day one and the taxes go into place on day one and the Medicare cuts go into place on day one and took the gimmicks out, this bill would generate a deficit, another promise the President pledged not to do.

There are so many problems with this bill. But most important today, as we will have an opportunity around 6 o'clock, is to vote to at least have the bill comply with the President's pledge.

I ask how much time remains.

The PRESIDING OFFICER. The Senator from Idaho has 3 minutes remaining.

Mr. CRAPO. Mr. President, I would like to reserve the remainder of my time, and I will hold that until later in the day.

The PRESIDING OFFICER. Who yields time? The Senator from Washington.

Ms. CANTWELL. Mr. President, I ask unanimous consent for 3 minutes out of Senator BAUCUS's time to make a statement.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Washington is recognized.

(The remarks of Ms. CANTWELL are printed in today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I wish to make a point. I know my colleague from Arizona wishes to engage in a brief colloquy on this point. The amendment we are offering, a bipartisan amendment dealing with the price of prescription drugs, is a very important amendment. We are going to get our vote on that, but then there is also going to be a vote on a poison pill amendment that nullifies it. It says if you pass the second amendment, it means nothing happens and prescription drug prices keep going through the roof.

I wish to say quickly there have been very few bipartisan amendments on the floor of the Senate during this health care debate. That is regrettable. This, in fact, is bipartisan. A wide range of 30 Senators, including Republicans JOHN MCCAIN, CHUCK GRASSLEY and OLYMPIA SNOWE and so on support this effort and the effort is simple, trying to put the brakes on prescription drug prices by giving the American people freedom and the ability to find competition among drug prices where they are sold in other parts of the world for a fraction of what we are charged as American consumers.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

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

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

Mr. MCCAIN. I think it is important for us to recognize what the Dorgan amendment is all about. It is about an estimated—according to the Congressional Budget Office, and we love to quote the Congressional Budget Office around here—$100 billion or more in consumer savings. That is what the Dorgan amendment does.

It cuts the cost of the legislation before us as much as $19.4 billion over 10 years. We are always talking about bending the cost curve, saving money, particularly for seniors who use more prescription drugs than younger Americans, and yet there is opposition.

I would like to ask my colleague from North Dakota, one, how long has he been fighting this issue; and, two, why in the world do we think anybody would be opposed to an amendment that would save $100 billion for consumers?

Mr. DORGAN. We have been working on this for 10 years—myself, the Senator from Arizona, and others. He knows because he was chairman of the Commerce Committee. We held hearings on this in the committee. The fact is, we have gotten votes on it before. In each case, the pharmaceutical industry, which has a lot of muscle around here, prevailed on those votes with an amendment that is a poison pill amendment saying somebody has to certify with respect to no additional safety risk and so on.

These safety issues are completely bogus, absolutely bogus. They have done in Europe for 20 years what we are proposing to do in this country, parallel trading between countries. What we are trying to do is save the American people $100 billion in the next 10 years because we are charged the highest prices in the world for prescription drugs, and there is no justification for it.

I want to show the Senator from Arizona one chart. This is representative. If you happen to take Nexium, for the same quantity you pay $424 in the United States, if you were in Spain, you would pay $36; France, $67; Great Britain, $41; Germany, $37. Why is it the American consumer has the privilege of paying 10 times the cost for exactly the same drug put in the same bottle made by the same company in the same plant? Justify that.

Mr. MCCAIN. Could I also ask my friend, has he seen this chart? This chart shows that the pharmaceutical companies in America increased wholesale drug costs, which doesn't reflect the retail drug cost, by some 8.7 percent just this year, while the Consumer Price Index—this little line here, inflation—has been minus 1.3 percent.

How in the world do you justify doing that? These are lists of the increases over a year in the cost of some of the most popular or much needed prescription drugs. Why would pharmaceutical companies raise costs by some 9 percent unless they were anticipating some kind of deal they went into?

I don't want to embarrass the Senator from North Dakota, but isn't it true that the President, as a Member of this body, cosponsored this amendment?

Mr. DORGAN. That is the case. The President was a cosponsor of this legislation when he served last year. I do

want to say as well the American consumer gets to pay 10 times the cost for Nexium. Nexium is for acid reflux, probably a condition that will exist with some after this vote because my understanding is, after 7 days on the floor of the Senate, there is now an arrangement by which the pharmaceutical industry will probably have sufficient votes to beat us, once again, which means the American people lose.

I also want to make this point. Anyone who stands up and cites safety and reads the stuff that has come out of a copying machine for 10 years, understand this: Dr. Peter Rost, former vice president of marketing for Pfizer, formerly worked in Europe on the parallel trading system, said:

> The biggest argument against reimportation is safety. What everyone has conveniently forgotten to tell you is that in Europe reimportation of drugs has been in place for 20 years.

It is an insult to the American people to say: You can make this work in Europe for the benefit of consumers to get lower prices, but Americans don't have the capability to make this happen, don't have the capability to manage it. That is absurd. This safety issue is unbelievably bogus.

Mr. MCCAIN. Haven't we seen this movie before? The movie I am talking about is that we have an amendment or legislation pending before the body or in committee that will allow for drug reimportation, as the Senator pointed out from that previous chart, in a totally safe manner. Then there is always, thanks to the pharmaceutical lobbyists—of which there are, I believe, 635 pharmaceutical industry lobbyists, a lobbyist and a half for every Member of Congress—an amendment that then basically prohibits the reimportation of drugs.

Haven't we seen this movie before? Apparently another deal was made so that they are now going to have sufficient votes to again cost the consumers $100 billion more in cost for the pharmaceutical drugs. Their representatives are here on the Senate floor ready to tout the virtues of an amendment which, as we all know, is a killer amendment. Let's have no doubt about that.

Mr. DORGAN. Mr. President, the Senator from Arizona is right. If this is ''Groundhog Day'' for pharmaceutical drugs, the clock strikes 6 and the pharmaceutical industry wins. They have been doing it for 10 years. We just repeat the day over and over again. My hope is that we will not have to repeat it today. My hope is that after a lot of work on a bipartisan piece of legislation, the American people will have sufficient support on the floor of the Senate to say it is not fair for us to be paying double, triple and 10 times the cost of prescription drugs that others in the world are paying.

I wonder if we might be able to yield some time to the Senator from Iowa, 5 minutes, unless the Senator from Arizona wishes to conclude.

Mr. MCCAIN. My only conclusion is that what we are seeing is really what contributes to the enormous cynicism on the part of the American people about the way we do business. This is a pretty clear-cut issue. As the Senator from North Dakota pointed out, it has been around for 10 years. For 10 years we have been trying to ensure the consumers of America would be able to get lifesaving prescription drugs at a lower cost. And the power of the special interests, the power of the lobbyists, the power of campaign contributions is now being manifest in the passage of a killer amendment which will then prohibit—there is no objective observer who will attest to any other fact than the passage of the follow-on amendment, the side-by-side amendment, will prohibit the reimportation of prescription drugs into this country which we all know can be done in a safe fashion and could save Americans who are hurting so badly $100 billion a year or more and cut the cost of the legislation before us by $19.4 billion. To scare people, to say that these drugs that are being reimported are not done in a safe manner to ensure that the American people's health is not endangered is, of course, an old saw and an old movie we have seen before. It is regrettable that the special interests again prevail at the power of the pharmaceutical lobby.

Of the many traits the Senator from North Dakota has that I admire, one of them is tenacity. I want to assure him that I will be by his side as we go back again and again on this issue until justice and fairness is done and we defeat the special interests of the pharmaceutical industry which have taken over the White House and will take over this vote that will go at 6 o'clock. It is not one of the most admirable chapters in the history of the Senate or the United States Government.

Mr. DORGAN. Mr. President, I yield 5 minutes to the Senator from Iowa.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, we have two key votes this afternoon on drug reimportation. These votes mean that today is the day we can show the American people whether we can pass drug importation or whether the Senate will give it lipservice and nothing else.

We have heard on the Senate floor the concerns that some have about drug importation and whether it can be safe. Everyone who knows me knows I care deeply about drug safety. The fact is, an unsafe situation is what we have today. Today consumers are ordering drugs over the Internet from who knows where, and the FDA does not have the resources, in fact, to do much of anything about it. The fact is, legislation to legalize importation would not only help to lower the cost of prescription drugs for all Americans but also should shut down the unregulated importation of drugs from foreign pharmacies, the situation we have today. The Dorgan amendment, in fact, would improve drug safety, not threaten it. It would open trade to lower cost drugs.

In 2004, my staff was briefed about an investigation that the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee conducted. That subcommittee conducted this investigation into what we would call going on right now, current drug importation. They found about 40,000 parcels containing prescription drugs come through the JFK mail facility every single day of the year, 40,000 packages each day.

Now the JFK airport houses the largest international mail branch in the United States, but even then that is the tip of the iceberg. According to this subcommittee, each day 30,000 packages of drugs enter the U.S. through Miami, 20,000 enter through Chicago. That is another 50,000 more packages each and every day.

What is worse, about 28 percent of the drugs coming in are controlled substances. So we have a situation where we need the basic approach in this amendment to assure that imported drugs are safe. That is what the Dorgan amendment is all about, to give FDA the ability to verify the drug pedigree back to the manufacturer, to require FDA to inspect frequently, and to require fees to give the FDA the resources to do that.

The bottom line is, the Dorgan amendment gives the FDA the authority and the resources it needs to implement drug importation safely.

Certainly, the President knows that a great way to hold drug companies accountable is to allow safe, legal drug importation. I would like to quote this President not when he was a candidate for President but a candidate for the Senate. This is what President Obama said then:

> I urge my opponent to stop siding with the drug manufacturers and put aside his opposition to the reimportation of lower priced prescription drugs.

Now we are hearing about the secret deal with big PhRMA. That was revised just this week to solidify support with PhRMA's allies for killing this very important Dorgan amendment. The drug companies will stop at nothing to keep the United States closed to other markets in order to charge higher prices.

With the Dorgan amendment, we are working to get the job done. What we need is to make sure Americans have even greater, more affordable access to wonder drugs by further opening the doors to competition in the global pharmaceutical industry.

Americans are waiting. Too often this thing has been stymied, and it looks like there is another chance to stymie it. Only I am surprised. Most of the time in the past that I have been for the importation of drugs, it was my colleagues over here who were trying to stymie it. But now it looks as though it is the other side. We ought to

have a vast majority for this amendment. I would be surprised. It would be a crime, if we didn't.

I yield the floor.

Mr. ROBERTS. Mr. President, I rise today to talk about prescription drug importation and patient safety. Senator DORGAN's amendment to allow for the importation of prescription drugs into the United States could have grave consequences for patient safety in America.

In a recent letter to my good friend and home State colleague Senator BROWNBACK, the Commissioner of the Food and Drug Administration, Dr. Margaret Hamburg, identified the four risks to patient safety that drug importation schemes pose: No. 1, the drug may not be safe or effective; No. 2, the drug may not be a consistently made, high quality product; No. 3, the drug may not be substitutable with an FDA-approved product; and No. 4, the drug may be contaminated or counterfeit.

That is a lot of risk to expose already-vulnerable patients to. And think about this: Malta. Cyprus. Latvia. Estonia. Slovakia. Greece. Hungary. Romania. These are just a few of the countries that could be exporting prescription drugs to the United States if the Dorgan amendment passes. As a former chairman of the Senate Intelligence Committee, I have grave concerns about the ability of these countries to adequately protect their drug supplies.

Our Food and Drug Administration, the FDA, is the gold standard for drug and product safety in the world, and even it has not been one hundred percent effective in preventing contaminated and counterfeit products from entering our supply chain. The recent scandals involving imported heparin, infant formula, and toothpaste have demonstrated the unfortunate limitations of the FDA's ability to conduct foreign inspections of food, drugs and cosmetics manufacturers abroad. If our own safety watchdog can't guarantee our protection, how can we expect that protection from Malta or Slovakia?

There is a real risk that these countries will be vulnerable to importing drugs from countries that are known for high rates of counterfeiting. In the European Union last year, 34 million counterfeit drugs were seized at border crossings in just 2 months. The World Health Organization estimates that drug counterfeiting rates in Africa and parts of Asia and Latin America are 30 percent or more. And up to 50 percent of medicines purchased from Internet sites that conceal their address are found to be counterfeit. Do we really want an HIV or cancer patient in Ohio, or Arizona or Kansas to rely on imported medicines that may have zero effectiveness, or which may even be harmful?

According to FDA Commissioner Hamburg, the Dorgan amendment does not adequately address these potential risks. In fact, the Commissioner says that the amendment ''would be logistically challenging to implement and resource intensive'' and that ''significant safety concerns . . . and safety issues'' remain.

Senator LAUTENBERG has introduced a side-by-side amendment to Senator DORGAN's, requiring that, before any law allowing the importation of prescription drugs into the United States can become effective, the Secretary of Health and Human Services must certify that such a scheme will both pose no additional risk to the public's health and safety, AND result in a significant reduction in costs for consumers.

I think that this amendment just makes sense. We must protect the prescription drug supply in America.

Mr. LEAHY. Mr. President, making medicine affordable is part of what health reform should be. Today we have the opportunity to include a measure long-championed by Senator DORGAN, which makes affordable prescription drugs more widely available to Americans.

Americans pay some of the highest prices for prescription drugs of any country in the world despite the fact that many of these drugs are made right here, and they are often made with the benefit of taxpayer supported research. Prescription drugs are a lifeline, not a luxury. The issue boils down to access: A prescription drug is neither safe nor effective if you cannot afford to buy it.

We have to recognize that this imposes real dangers on American consumers when they cannot follow their doctor's treatment plan because they can't afford their medicine. While we must do more to bring affordable healthcare to the millions of Americans who are currently uninsured or who do not have good coverage, we cannot continue to deny them this immediate market-based solution.

I am proud to be a cosponsor of the Dorgan-Snowe amendment to allow pharmacies and drug wholesalers in the United States to import the very same medications that are FDA-approved in the United States from Canada, Europe, Australia, New Zealand, and Japan where prices are 35–55 percent lower than in the United States. Consumers will be able to purchase the very same prescription medications from their local pharmacies at a third or half of the cost. Additionally, the legislation would also allow individuals to purchase prescription drugs from FDA-inspected Canadian pharmacies—something Vermonters have crossed the border to do many times before.

For many Vermonters today, purchasing drugs from Canada literally means the difference between following their doctors' orders and having to throw the dice with their health and sometimes even with their lives by doing without their prescription medicines. It makes the difference for the woman who has maxed out her health plan's annual prescription drug benefit only three months into the year and is then faced with purchasing the other nine months worth of medicine at U.S. prices on her own. It makes the difference for the elderly man on a fixed income who is unable to afford both the heart medicine he needs to live, and the gas bill he needs to keep warm. Are we prepared to tell those in dire need that they must go back to choosing between paying gas, food, and heating bills, or their medicine?

Of course not, and I urge my fellow Senators to support the Dorgan-Snowe amendment.

Mr. ENZI. Mr. President, I rise today to talk about prescription drug importation. As my colleagues know, I oppose this proposal.

It is our job as Senators to debate the issues, put forward our ideas, and show where we stand. I was disappointed that Democratic leadership chose to prevent the Senate from voting on amendments to improve this bill for the past 6 days. I am, however, glad the impasse has finally been resolved.

I am not afraid to show where I stand on this issue. Some of my colleagues on both sides of the aisle support importation. Some, like me, oppose it. But my position is clear, and does not change with the political winds.

The winds I am referring to include the arrangement that was reportedly negotiated with the drug manufacturers. Under the terms of this backroom deal, the drug manufacturers have reportedly agreed to $80 billion in price cuts and provided a commitment to spend $150 million in ads supporting the Reid bill.

In exchange, Senate Democratic leadership and President Obama have reportedly agreed to block efforts to enact drug importation from Canada.

According to one Wall Street analyst's report, the Reid bill is expected to increase drug company profits by more than $137 billion over the next 4 years. Let's do the math on that: $80 billion in cuts, leading to $137 billion in increased profits.

While this may be a good deal from the drug manufacturers and Senate Democrats, it certainly is not a good deal for the American people. Part of the reported deal will actually increase Medicare costs to the taxpayer, because it creates an incentive for Medicare beneficiaries to continue using brand-name drugs.

According to the Congressional Budget Office, Federal Medicare costs will be increased by $15 billion over the next decade as a result of this deal. In the last few days, there have been new press reports highlighting how the drug manufacturers may have agreed to provide even deeper discounts on their brand-name drugs. No one knows how much more this deal will cost the taxpayers.

In addition to increasing the price Americans will pay for the Reid bill, this deal appears to have also undermined Democratic support for a drug importation amendment.

My colleagues who believe importation is the right way to lower drug

costs say that it will save the government $19 billion and consumers $80 billion over the next 10 years.

The majority leader has previously voted for drug importation. President Obama supported drug importation when he was in the Senate. The supporters of drug importation should be able to easily pass this amendment without any limitations.

Yet it looks like the supporters of drug importation will not succeed today. It appears likely that safety certification language, similar to language included in prior years, will be added to this proposal.

My colleagues each know where they stand on the issue. But the deal with the drug manufacturers is apparently so important that supporters of drug importation are going to vote against the proposal.

It is important for the American people to understand why there has been this change of heart on this issue. The drug manufacturers are one of the few remaining health care groups that still support the Reid bill. They have committed to spend $150 million to buy television ads to support the Democrats efforts on health reform.

If my Democratic colleagues fail to adopt drug importation without the safety language, it is because the Senate Democratic leadership and the White House have decided they will do whatever it takes to keep the support of the drug manufacturers. They believe that the money these companies will spend will be enough to convince the American people to support their efforts.

The American people already understand that the Reid bill is not a good deal for them. They understand how this bill will raise their taxes, increase their insurance premiums and cut Medicare benefits for millions of seniors.

That is why over 60 percent of Americans now oppose the Democratic health reform proposals. No amount of advertising, funded by the drug companies or anyone else, is going to change that reality.

Mr. LEVIN. Mr. President, it has become apparent that passage of this Dorgan amendment relative to importation of prescription drugs, an amendment which I have long supported, could threaten passage of broader health care reform. If so, the perfect would become the enemy of the good. For that reason, I will vote ''no'' on the Dorgan amendment on this bill.

The PRESIDING OFFICER. The Senator from New Jersey.

AMENDMENT NO. 3156 TO AMENDMENT NO. 2786

(Purpose: To provide for the importation of prescription drugs)

Mr. LAUTENBERG. Mr. President, I offer time to my colleague from New Jersey, Senator MENENDEZ—up to 11 minutes.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. MENENDEZ. Mr. President, I appreciate my distinguished senior colleague from New Jersey yielding time. I know he is going to call up his amendment shortly, and that is what I want to speak to.

Mr. President, before I get to the core of my remarks, I want to tell my colleague who left the floor, I was tempted to rise under rule XIX that says:

> No Senator in debate shall, directly or indirectly, by any form or words impute to another Senator or to other Senators any conduct or motive unworthy or unbecoming a Senator.

I could impute, if I wanted to, I guess, that maybe there are some who really do not care about this plan as much as they care about killing health care reform, but I would not do that. I would not do that. So I hope in the context of the debate I am not forced to rise under rule XIX.

Mr. President, I rise in favor of the amendment of Senator LAUTENBERG, who is going to offer it shortly, because it does two things that underscore the entire debate about health care reform: It protects the American people by putting the safety of families first—and there is a lot of brushing aside of safety here; safety is paramount; safety is paramount—and it lowers costs. At its core, that is what this health care debate is all about.

I appreciate the intentions of the amendment that has been offered on the floor, but in my view it is regressive. It harkens back to a time when the lack of sufficient drug regulation allowed people to sell snake oil and magic elixirs that promised everything and did nothing. To allow the importation of untested, unregulated drugs made from untested and unregulated ingredients from 32 countries into the medicine cabinets of American families without serious safety precautions flies in the face of protecting the American people, and it is contrary to the context of health care reform.

The amendment by Senator LAUTENBERG brings us around to the real purpose of why we have been here on the floor, which is to create the type of reform that ultimately gives greater health insurance and greater safety to the American people.

They care about honest, real reform that makes health care affordable and protects American families, protects them from the potential of counterfeit drugs that promise to cure but do absolutely nothing, just as we are here to protect them from insurance policies that promise to provide health care for a premium and then deny coverage and provide no health care at all.

Basically, what Senator LAUTENBERG's amendment is going to do is modify the Dorgan amendment to allow reimportation but to do it when basic safety concerns to keep our prescription medications safe are complied with. It includes the Dorgan importation amendment but adds one fundamental element of broader health care reform: It protects the American people from those who would game the system for profits at the expense of the health and safety of American families. That is what this reform is all about. Specifically, when it comes to the importation of prescription medication, this amendment will help us be sure that what we think we are buying in the bottle is, in fact, what is in that bottle.

I want to make reference to a letter. We talk about safety, and there is a lot of pooh-poohing that, oh, there are no safety concerns. Well, there is one entity in this country that is responsible for safety when it comes to food and drugs, and it is called the FDA, the Food and Drug Administration. In a letter from FDA Commissioner Hamburg, she mentions four potential risks to patients that, in her opinion, must be addressed:

First, she is concerned that some imported drugs may not be safe and effective because they were not subject to a rigorous regulatory review prior to approval.

Second, the drugs ''may not be a consistently made, high quality product because they were not manufactured in a facility that complied with appropriate good manufacturing practices.''

Third, the drugs ''may not be substitutable with the FDA approved products because of differences in composition or manufacturing . . . ''

Fourth, the drugs simply ''may not be what they purport to be'' because inadequate safeguards in the supply chain may have allowed contamination or, worse, counterfeiting.

It addresses FDA Commissioner Hamburg's statement about the amendment of my colleague from North Dakota:

> that there are significant safety concerns related to allowing the importation of non-bioequivalent products, and safety issues—
>
> ''Safety issues''—
>
> related to confusion in distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

Senator LAUTENBERG's amendment addresses this concern. It allows importation, but it protects the American people by requiring that before any drug is imported to the United States, it must be certified to be safe and to reduce costs. So it does what the FDA Commissioner is talking about here, the agency responsible for protecting the American people. People may just want to not believe it, they may want to ignore it, but the fact is, this is the entity responsible in this country to protect the food supply and the drug supply.

We want to be as certain as we possibly can be of the conditions under which imported drugs are manufactured, that they are safe to use and we know where their ingredients originated before they are imported. We want to be absolutely certain patients are getting the prescription medications that are the same in substance, quality, and quantity that their doctor has prescribed. This amendment requires the Secretary of Health and

Human Services to certify that all imported drugs are safe and will reduce costs before they are allowed into America's medicine cabinets.

I have heard a lot about the European Union here. Well, let's look at what the European Union is now saying. They are constantly being offered on the floor for the reason why, in fact, we should follow what the European Union is saying. Well, let's see what happens if we allow unregulated importation. Let's look at the European Union.

Last week, the European Union Commissioner in charge of this issue said:

> The number of counterfeit medicines arriving in Europe . . . is constantly growing. The European Commission is extremely worried.
>
> In just two months, the EU seized 34 million—

Hear me: ''million''—

> fake tablets at customs points in all member countries. This exceeded our worst fears.

I do not want American families to see those fears come to life here. I believe that if we do not pass the Lautenberg amendment and if we were to pass the Dorgan amendment, we would open the floodgates. The European Union's experience only proves my concerns, not alleviates them as the other side would suggest.

Here is the problem: a $75 counterfeit cancer drug that contains half of the dosage the doctor told you you needed to combat your disease does not save Americans' money and certainly is not worth the price in terms of dollars or risk to life.

Let's not now open our national borders to insufficiently regulated drugs from around the world. It seems to me real health reform—particularly for our seniors and those who are qualified under the Medicare Program who receive their prescription coverage under that—comes by filling the doughnut hole in its entirety, which we have declared we will do in the conference, as we are committed to do, that provides for the coverage of prescription drugs that AARP talks about on behalf of its millions of members. That is what we want to see—not by unregulated reimportation.

We should have no illusions, keeping our drug supply safe in a global economy, in which we cannot affect the motives and willingness of others to game the system for greed and profit, will be a monumental but essential task. It will require a global reach, extraordinary vigilance to enforce the highest standards in parts of the world that have minimum standards now, so we do not have to ask which drug is real and which is counterfeit.

Let me just show some examples of those. People say: Oh, no, this safety issue is not really the case.

Tamiflu. We saw a rush, when the H1N1 virus came. People wanted to buy Tamiflu. As shown on this chart, which is the real one and which is the counterfeit one? There actually is one that is approved and one that is counterfeit, but the average person would not know the difference. Or if it is Aricept, a drug to slow the progression of Alzheimer's disease, which one is the real one and which one is the counterfeit one? If I did not tell you from the labels, you probably would not know, but there is an approved one and there is a counterfeit one. As someone who lost his mother to Alzheimer's, I can tell you that having the wrong drug in the wrong dosage would not have helped her slow the progression of her illness. It makes a difference.

Let's look at others. Lipitor; very important. You are walking around with a real problem with cholesterol, and you think you are taking the appropriate dosage and the appropriate drug. But, as shown on this chart, which is the real one and which is the counterfeit one? There is a counterfeit one and there is an approved one, a real one, but if you are taking the counterfeit one and you think you are meeting your challenges, you might have a heart attack as a result of not having the real one. By the time you figure it out, it could be too late to reverse the damage. That is the problem. That is the global economy opening up possibilities at the end of the day.

Mr. President, I ask the Senator from New Jersey for an additional minute.

Mr. LAUTENBERG. Mr. President, I yield 1 more minute to the Senator.

Mr. MENENDEZ. Finally, this is a gamble we cannot afford to take: To open up the potential for these drugs—or the ingredients used in these drugs—to find their way from nation to nation, from Southeast Asia, where the problem is epidemic, to one of the 32 nations listed in this amendment and then into the homes of American families. That is a gamble we cannot take. That is not about protecting our citizens. That is not about providing prescription drugs that ultimately meet the challenge of a person's illness. Filling the doughnut hole totally, which is what we are going to do, is the way to achieve it.

So I do hope that is what we will do. I do hope we will adopt Senator LAUTENBERG's amendment and defeat the Dorgan amendment, for I fear for the safety of our citizens, and I fear as to whether we can ultimately achieve filling that doughnut hole if this amendment, ultimately, gets adopted, and I fear what that means for health care reform at the end of the day.

With that, Mr. President, I yield back the remainder of my time and thank the Senator from New Jersey.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I call up amendment No. 3156—it is at the desk—and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

> The Senator from New Jersey [Mr. LAUTENBERG], for himself, Mr. CARPER, and Mr. MENENDEZ, proposes an amendment numbered 3156 to amendment No. 2786.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

(The amendment is printed in the RECORD of Thursday, December 10, 2009, under ''Text of Amendments.'')

Mr. LAUTENBERG. Mr. President, I rise today because one thing we have to do as we progress with this health care reform bill is to make sure prescription medicine in our country is safe and affordable. I thank my colleague from New Jersey for his excellent review of the conditions that cause us to add this amendment to Senator DORGAN's amendment that would allow potentially unsafe prescription drugs to be shipped across our borders and directly into the medicine cabinets of homes throughout America.

I want to be clear, the effect of this plan Senator DORGAN has offered could be catastrophic. That is why President Obama's administration has written to the Congress expressing its serious concerns with the Dorgan amendment.

I appreciate the efforts to try to lower prescription drug prices. After all, that is what we are doing with the whole health reform review—trying to get costs reduced so everyone can have safe and affordable health care. We want to make sure people do not harm their health with any shortcuts.

We all want Americans to stay healthy and still have some money left in their pockets. But as much as we want to cut costs for consumers, we cannot afford to cut corners and risk exposing Americans to drugs that are ineffective or unsafe.

The fact is, this is a matter of life and death. The European Commission just discovered that counterfeit drugs in Europe are worse than they feared. In just 2 months—and I know Senator MENENDEZ made reference to this as well—the EU seized 34 million fake tablets, including antibiotics, cancer treatments, and anticholesterol medicine.

As the industry commissioner of the EU said:

> Every faked drug is a potential massacre. Even when a medicine only contains an ineffective substance, this can lead to people dying because they think they are fighting their illnesses with a real drug.

Americans buy medicine to lower their cholesterol, fight cancer, and prevent heart disease. Imagine what would happen to a mother or a child if they start relying on medicine imported from another country only to find out years later that the drug was a fake. Imagine the heartbreak that might ensue if the medicine Americans were taking was found to be harmful. The fact is that drugs from other countries have dangerously high counterfeit rates and importation could expose Americans to those drugs.

Under the Dorgan amendment, drugs would be imported from former Soviet Union countries where the World Health Organization estimates that

over 20 percent of the drugs are counterfeit. Under the Dorgan amendment, drugs that originate in China could find their way into our homes. We know that China has been the source of many dangerous products in recent years, from toys laced with lead to toothpaste made with antifreeze.

If we are going to trust drugs from other countries, we need to be absolutely certain we are not putting Americans' lives at risk. That is why the Food and Drug Administration went on record to express its concerns with the Dorgan amendment. They say:

> There are significant safety concerns related to allowing the importation of non-bioequivalent products, and safety issues related to confusion in distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

That is from the FDA Commissioner Margaret Hamburg.

There are problems associated with the possibility of drugs coming to this country that are way different than that which is expected to be used in the treatment of sickness.

President Obama's FDA Commissioner also wrote and said that importing drugs presents a risk to patients because the drug may not be safe and effective, may not have been made in a facility with good manufacturing practices, and may not be the drug it claims to be.

In light of the serious concerns raised by the Obama administration, I am offering an amendment to require that the Department of Health and Human Services certify that the drugs are safe and will reduce costs before they are imported. My amendment is a commonsense bipartisan alternative to the Dorgan amendment. In fact, it is the exact same language as the Dorgan importation amendment, but with the certification requirement that is so important to ensure safety.

If we are going to allow the importation of drugs from other countries, we have to be certain they are safe and affordable. With this amendment, I would be in support of the Dorgan amendment. Only certification by health experts will provide that assurance. I urge my colleagues to support my amendment and oppose the Dorgan amendment.

We have no way of knowing what the working conditions might be like in a plant or a facility, or the sanitary conditions, in other countries, or whether in the process of packing and shipping temperatures might not be appropriate for the product to arrive without deterioration. Thusly, again, I stress—bring in what you want, just make sure it is safe for the people. There is no moment in the discussion we have had about the health care reform bill that says, Look, you can save money by taking a chance on a shortcut here or a shortcut there. Absolutely not. We wouldn't think of proposing anything such as that, and we ought not to be proposing it here now.

I yield 5 minutes to my colleague from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina.

Mrs. HAGAN. Mr. President, I rise today to speak about drug reimportation. With millions of seniors balancing drug regimens that entail taking several medicines per day on a fixed income, I believe we need to find a way to ensure that they have access to affordable drugs. If we could reduce the cost of drugs with reimportation and guarantee the safety of those drugs, I would be very supportive. However, I have serious doubts that we can adequately ensure the safety of our drug supply with the drug reimportation amendment proposed by my colleague from North Dakota.

Even without reimportation, the United States has had trouble with counterfeit drugs. At the height of the H1N1 epidemic this fall, the FDA was warning consumers to be wary of counterfeit H1N1 treatments. These counterfeits came from foreign online pharmacies. In one instance, the FDA seized so-called H1N1 treatment tablets from India and found them to contain talc and acetaminophen. Last month, the Washington Post reported on a coordinated global raid of counterfeit drugs from the United States to Europe to Singapore. The United States discovered about 800 alleged packages of fake or suspicious prescription drugs, including Viagra, Vicodin, and Claritin, and shut down 68 alleged rogue online pharmacies.

Counterfeit pharmaceutical drugs are appearing on the market at increasingly alarming rates. In 2007, drugs comprised 6 percent of the total counterfeit product seizures. In 1 year, they have now jumped to 10 percent of all counterfeit product seizures.

This growing problem is all about unscrupulous criminals preying on the sick and the elderly who are in desperate need of cheaper drugs. But the consequences are harmful and, in some cases, deadly.

Officials estimate that some of these counterfeit drugs contain either a dangerous amount of active ingredients or were placebos. Some counterfeits include toxic chemicals such as drywall material, antifreeze, and even yellow highway paint.

According to a recent Washington Post article, tracing the origins of drugs such as Cialis and Viagra took investigators across the globe and back again. Supposedly these drugs came from a warehouse in New Delhi, though the online company selling the drug was headquartered in Canada and was licensed to sell medicine in Minnesota. However, when Federal officials investigated the drug origins further, they actually found that the online Web site was registered in China, its server was hosted in Russia, and its headquarters had previously been listed in Louisiana.

On a local level near our capital, the Baltimore Sun yesterday reported on the death of a University of Maryland pharmacologist, Carrie John. Ms. John suffered an allergic reaction to a counterfeit version of a legal drug in the United States but purchased illegally from the Philippines. Apparently, the counterfeit drug so closely resembled the legal version that two pharmacologists conducting the analysis after Ms. John's death could not tell the difference. Local police have yet to identify the contents of the counterfeit drug.

A few of my colleagues have already mentioned the letter sent last week by FDA Commissioner Margaret Hamburg outlining the safety concerns the FDA has about reimportation. Specifically, the FDA stated that importing non-FDA-approved prescription drugs posed four potential risks to patients. Let me go over those four risks.

No. 1: The drug may not be safe and effective because it did not undergo the rigorous FDA regulatory review process.

No. 2: The drug may not be a consistently made, high quality product because the facility in which it was manufactured was not reviewed by the FDA.

No. 3: The drug may not be substitutable with the FDA-approved product because of differences in composition or manufacturing.

No. 4: The drug could be contaminated or counterfeit as a result of inadequate safeguards in the supply chain.

If the agency that oversees drug safety is saying it would have difficulty guaranteeing the safety of our Nation's drug supply with reimportation, I have grave concerns, particularly since the FDA is already underfunded and understaffed.

But let's take a moment to examine how Europe, which does allow reimportation, has fared in terms of safety.

British authorities say counterfeit drugs often exchange hands between middlemen and are repackaged multiple times before reaching a legitimate hospital or pharmacist. This creates opportunities for counterfeit products, often produced in China and shipped through the Middle East, to penetrate the European market.

The PRESIDING OFFICER. The Senator has used her 5 minutes.

Mrs. HAGAN. Mr. President, I ask unanimous consent for 3 additional minutes.

Mr. LAUTENBERG. No objection.

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

Mrs. HAGAN. In 2008, British authorities identified 40,000 doses of counterfeit Casodex, a hormone treatment for men with advanced prostate cancer, and Plavix, a blood thinner.

More recently, the European Union seized 34 million fake tablets at customs points in all member countries. In other countries around the world, the World Health Organization estimates that up to 30 percent of the medicines on sale may be counterfeit. As a result, numerous people have died.

Earlier this year, 80 infants in Nigeria died from teething medicine that contained a toxic coolant. In July, 24 children in Bangladesh died from the consumption of poisonous acetaminophen syrup.

The Dorgan amendment does not require imported drugs to be FDA approved or meet FDA misbranding standards. Furthermore, it does not prevent criminals in other countries from repackaging imported drugs.

Although our safety system is not perfect, we have a thorough FDA review system for drug safety that actively involves physicians, pharmacists, and patients. As a result, Americans can be generally confident that our medications are safe and contain the ingredients on the bottle.

Supporters of reimportation argue that the sick and elderly need an alternative way to obtain affordable drugs. However, a study by the London School of Economics found that in the European Union, middlemen reaped most of the profits with relatively little savings passed down to the consumer. Nothing in the Dorgan amendment requires the savings to be passed on to the consumer, leaving the door wide open for unscrupulous, profit-seeking third parties to get into the reimportation game.

In the United States, we are already trying to reduce the cost of prescription drugs through the use of generics. This is one of the most effective ways for customers to reap savings, and the generic dispensing rate at retail pharmacies is close to 65 percent. The FDA is already working with stakeholders to develop drug reimportation policy. With the FDA looking into this and significant outstanding safety concerns, I cannot in good conscience support the amendment offered by my colleague from North Dakota. Instead, I will support the amendment offered by my colleague from New Jersey. The Lautenberg amendment will allow the importation of drugs only if the Secretary of Health and Human Services certifies that doing so would save money for Americans and would not adversely affect the safety of our drug supply.

While it is critical that all Americans, especially our Nation's seniors, have access to affordable drugs, it is imperative that we not compromise the safety of U.S. drugs on the market. After all, what good are cheap drugs if they are toxic or ineffective?

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

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I believe my colleague from North Dakota intends to make further remarks. How much time do we have on our side, please?

The PRESIDING OFFICER. The Senator from New Jersey controls 13 minutes.

Mr. LAUTENBERG. Thirteen minutes.

Mr. President, if Senator DORGAN is here, then we are trying to accommodate a colleague who wishes to speak on this. How much time is left on the Dorgan side?

The PRESIDING OFFICER. The Senator from North Dakota has 28 minutes remaining.

Mr. LAUTENBERG. Mr. President, we heard about what is happening in the EU having to do with the question of whether drugs are counterfeit and the serious consequences of having people take medication that is not what it is supposed to be—the consequences of something like that, especially interfaced with other products.

There was a news report last week that was printed in Yahoo News. They quote the Industry Commissioner of the European Union—the program in Europe that controls drug safety or at least attempts to. We see that the European Union has expressed concern about the situation they see there. The Commissioner, Mr. Verheugen, said he expected the EU to take action to fight the menace of fake pharmaceuticals. Then he said he thought the EU would agree, in 2010, that a drug's journey from manufacture to sale should be scrutinized carefully and there will be special markings on the packages.

There is a lot of concern about this, and we ought not to dash willy-nilly through here without understanding what the consequences of fake medication might be. I wish to see our people pay as little as they can to get the medicines they need. Part of that has to include a safety factor. As I said earlier, we would not suggest anything in the health reform bill that would take a shortcut and disregard safety. I have a letter that was sent from the Department of Health and Human Services, which I quoted a little bit ago. They say the letter is being sent on the amendment filed by Senator DORGAN. The administration supports this program, which I agree to, to buy safe and effective drugs from other countries and included $5 million in our 2010 budget.

They go on to say—and this is from the Commissioner of Food and Drugs—that:

> Importing non-FDA-approved prescription drugs presents four potential risks to patients that must be addressed: (1) the drug may not be safe and effective because it was not subject to a rigorous regulatory review prior to approval; (2) the drug may not be consistently made, high quality product because it was not manufactured in a facility that complies with appropriate good manufacturing practices; (3) the drug may not be substitutable with the FDA-approved product because of differences in composition or manufacturing; and (4) the drug may not be what it purports to be, because it has been contaminated or is a counterfeit due to inadequate safeguards in the supply chain.

I ask unanimous consent that this letter, sent to Senator TOM CARPER, from the Department of Health and Human Services, be printed in the RECORD.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES, FOOD AND DRUG ADMINISTRATION,
Silver Spring, MD, December 8, 2009.

Hon. TOM CARPER,
U.S. Senate,
Washington, DC.

DEAR SENATOR CARPER: Thank you for your letter requesting our views on the amendment filed by Senator Dorgan to allow for the importation of prescription drugs. The Administration supports a program to allow Americans to buy safe and effective drugs from other countries and included $5 million in our FY 2010 budget request for the Food and Drug Administration (FDA or the Agency) to begin working with various stakeholders to develop policy options related to drug importation.

Importing non-FDA approved prescription drugs presents four potential risks to patients that must be addressed: (1) the drug may not be safe and effective because it was not subject to a rigorous regulatory review prior to approval; (2) the drug may not be a consistently made, high quality product because it was not manufactured in a facility that complies with appropriate good manufacturing practices; (3) the drug may not be substitutable with the FDA-approved product because of differences in composition or manufacturing; and (4) the drug may not be what it purports to be, because it has been contaminated or is a counterfeit due to inadequate safeguards in the supply chain.

In establishing an infrastructure for the importation of prescription drugs, there are two critical challenges in addressing these risks. First, FDA does not have clear authority over foreign supply chains. One reason the U.S. drug supply is one of the safest in the world is because it is a closed system under which all the participants are subject to FDA oversight and to strong penalties for failure to comply with U.S. law. Second, FDA review of both the drugs and the facilities would be very costly. FDA would have to review data to determine whether or not the non-FDA approved drug is safe, effective, and substitutable with the FDA-approved version. In addition, the FDA would need to review drug facilities to determine whether or not they manufacture high quality products consistently.

The Dorgan importation amendment seeks to address these risks. It would establish an infrastructure governing the importation of qualifying drugs that are different from U.S. label drugs, by registered importers and by individuals for their personal use. The amendment also sets out registration conditions for importers and exporters as well as inspection requirements and other regulatory compliance activities, among other provisions.

We commend the sponsors for their efforts to include numerous protective measures in the bill that address the inherent risks of importing foreign products and other safety concerns relating to the distribution system for drugs within the U.S. However, as currently written, the resulting structure would be logistically challenging to implement and resource intensive. In addition, there are significant safety concerns related to allowing the importation of non-bioequivalent products, and safety issues related to confusion in distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

We appreciate your strong leadership on this important issue and would look forward to working with you as we continue to explore policy options to develop an avenue for the importation of safe and effective prescription drugs from other countries.

Sincerely,

MARGARET A. HAMBURG,
Commissioner of Food and Drugs.

Mr. LAUTENBERG. Mr. President, I will now suggest the absence of a quorum and ask unanimous consent that it be charged equally to both sides.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Reserving the right to object, Mr. President. You can't do that to us because we only have 8½ minutes left on our side.

Mr. LAUTENBERG. You have considerably more based on—

Mr. GRASSLEY. We only have 8½ minutes.

Mr. DORGAN. Mr. President, I ask the Senator to withhold his request for a quorum.

Mr. LAUTENBERG. Yes, I withdraw the request.

Mr. DORGAN. Mr. President, back in the mid-1800s, when Lincoln and Douglas were having their famous debates, at one point Lincoln was exasperated because he could not get Douglas to understand something he was saying. He said to Douglas: Listen, how many legs does a horse have? Douglas said: Four, of course. Lincoln said: If you call the tail a leg, how many legs would he have? Douglas said: Five. Lincoln said: There is where you are wrong. Simply calling a tail a leg doesn't make it a leg at all.

Yes, that is exactly what my colleagues have done, suggesting the amendment we are offering is for untested, unregulated drugs. It is not true. The only drugs we are talking about are FDA-approved drugs that are made at an FDA-inspected plant, part of a chain of custody equal to the U.S. chain of custody. It is simply not true that we are talking about untested, unregulated drugs. That is not true. Simply saying that doesn't make it true.

Here is why we are on the floor of the Senate. We are reforming health care. That is what the bill is. Part of health care is prescription drugs. A lot of people take prescription drugs to keep them out of a hospital bed. It manages their disease. Prescription drugs are very important.

Here is what happened to the prices year after year. As you can see on this chart, the rate of inflation is in yellow and the prescription drug prices are in red. This year alone, it is up 9 percent, at a time when inflation is below zero.

Well, why do we want to be able to access the same FDA-approved drug where it is sold elsewhere at a fraction of the price? Because the American people will pay in the next decade—if we don't pass this legislation—$100 billion in excess prescription drug prices. If you need to take Nexium for acid reflux—maybe after this vote we will all need it. But if you are going to buy Nexium, it costs $424 for an equivalent quantity in the United States. You can buy it for $41 in the UK, $36 in Spain—but it is $424 here. Sound fair? Not to me.

Lipitor is the most popular cholesterol-lowering drug in the world. It is $125 in the United States for an equivalent quantity. You get the same thing for $40 in the UK or one-third of the price. It is $32 in Spain, one-fourth the price. It is $33 in Canada. The American people get to pay triple or quadruple the price. By the way, it comes in these bottles. I ask unanimous consent to use the bottles.

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

Mr. DORGAN. They both contained Lipitor that is made in Ireland by an American corporation. They have different colored labels, but they are made in the same plant, FDA approved, and they are sent to different places—this one to Canada and this one to the United States. But we have the privilege of paying triple the price. Sound fair? Not to me it doesn't.

Here is a sample. Boniva, for osteoporosis, is up 18 percent this year. Singulair, for asthma, is up 12 percent. Enbrel, for arthritis, is up 12 percent. Here is Plavix—the list goes on.

The question is, Is there something we ought to do about this or should we say let's pass health care reform and ignore what is happening to the price of prescription drugs? This amendment I offered, along with Senators MCCAIN and GRASSLEY and other colleagues on this side—30 cosponsors—is all about freedom for the American people. If this is a global economy, how about giving the American people the freedom to access identical prescription drugs, which we know are identical because we require safety if it doesn't even exist in our own supply. Those who talk about safety, I remind them 40 percent of the active ingredients in prescription drugs of the United States come from India and China—from places that have never been inspected.

The Wall Street Journal did terrific expose about this. There were over 60 people who died from Heparin in this country. It was contaminated. Here is where they were making it. This picture was in the investigation. Here is a rusty old pot being stirred with a limb from a tree. Those are active ingredients for American drugs. This guy is working with pig intestines—guts from a hog. This old man here, with a wooden stick—it looks unsanitary doesn't it? That is the source of Heparin. These are the photographs by the Wall Street Journal investigative reporter. They are telling us FDA-approved drugs coming from other countries, with a chain of custody identical to ours, would pose some sort of threat. Are you kidding? You can make that charge without laughing out loud?

Let's talk about the existing drug supply for a moment. This is a young man named Tim Fagan. He was a victim of counterfeit domestic drugs in this country—not imported FDA-approved drugs. Do you know where this guy's drug came from? Here is the report done on that. It is made by Amgen. It went through all these places. It ended up at a place called Playpen, which is a south Florida strip club—in a cooler in the back room of a south Florida strip club. At one point it was stored in car trunks. Finally, it was prescribed and administered to this young man named Tim Fagan. He survived, but he was getting medicine with one-twentieth the necessary strength for a serious disease that his doctor intended for him.

Don't talk to me about the issue of prescription drug safety. We are talking about safety that doesn't now exist in the domestic drug supply, but safety standards are included in this amendment. Every drug should have a pedigree to track where it came from and, in every respect, between manufacture and consumption. There ought to be batch lots and tracers for every drug. There ought to be pedigree for the domestic drug supply as well.

I wish to quote a former vice president of Pfizer Corporation, a prescription drug manufacturer, Dr. Peter Rost:

> Right now, drug companies are testifying that imported drugs are unsafe. Nothing could be further from the truth.

This is from a vice president of one of the major drug companies—''nothing can be further from the truth.'' He was fired, to be sure. You can't say that if you are working for a drug company. Their business is to try to keep the pricing strategy the way it is.

I might say, I don't have a beef with the drug industry. I have a beef with their pricing policy that says we will sell the same drug everywhere in the world at a fraction of the price we charge the American consumer. How do you make that stick? By a sweetheart deal in law that says the American consumer cannot import the drug. The Spanish can import drugs from Germany. The French can import drugs from Italy. But the American consumer is told you don't have the freedom to shop for that same FDA-approved drug—approved because the place where it is produced is inspected by the FDA, in a country with an identical chain of custody, but the U.S. consumer doesn't have the freedom to make that purchase.

If I might, Dr. Peter Rost, the same guy just I quoted, said:

> During my time responsible for a region in northeastern Europe, I never once—not once—heard the drug industry, regulatory agencies, the government, or anyone else say this practice was unsafe, and I personally think it is outright derogatory to claim that the Americans would not be able to handle the reimportation of drugs, when the rest of the educated world can do this.

Dr. Peter Rost also said:

> The biggest argument against reimportation is safety. What everyone has conveniently forgotten to tell you is that, in Europe, reimportation of drugs has been in place for 20 years.

Hank McKinnell, a former Pfizer CEO, said:

> Name an industry in which competition is allowed to flourish—computers, telecommunications, small package shipping, retailing, entertainment, and I'll show you lower prices, higher quality, more innovation, and better customer service. There is

nary an exception. OK, there is one. So far, the health care industry seems immune to the discipline of competition.

Nowhere is that more evident with respect to pharmaceutical drugs.

The question today is, Will we once again offer a prescription drug importation bill that will save consumers and the Federal Government $100 billion; that contains safety standards that do not exist even in the domestic drug supply; that will not pose risk but, in fact, reduces risk, reduces prices for the American people, provides fair pricing for American consumers? Will we be able to vote for that legislation that I and Senator MCCAIN, Senator GRASSLEY, Senator STABENOW, Senator KLOBUCHAR, and so many others have brought to the floor of the Senate? The answer is, yes; we are going to vote on that.

The question is, In the 7 days since I have offered this amendment, has the pharmaceutical industry been able to pry enough people away from this amendment because they are raising all kinds of issues of safety?

How many votes will we get? By the way, the side-by-side amendment is a killer amendment. We will have a second vote. A lot of people will say: We will vote for the Dorgan amendment and then vote to nullify it by voting for the Lautenberg amendment.

Let me read the AARP letter which was sent yesterday:

On behalf of the AARP's nearly 40 million members, we urge you to support the Dorgan-Snowe importation amendment to . . . H.R. 3590, the Senate health care reform legislation. This amendment provides for the safe, legal importation of lower-priced prescription drugs from abroad. CBO has scored the amendment as saving taxpayers more than $19 billion.

That is just for the Federal Government. There is much more for consumers.

We also urge you to vote against an alternative importation amendment proposed by Senators Lautenberg, Carper, and Menendez. AARP strongly opposes this amendment because it includes the unnecessary addition of a certification requirement which is simply a thinly veiled effort to undermine importation and preserve the status quo of high drug prices.

So there it is. We are always told this bill is a finely crafted piece; it is like embroidering with some sophisticated colors. This is a finely crafted piece and don't mess with it because if you adopt your amendment, somehow the whole thing is going to come apart. It is like pulling a thread on a cheap suit. You pull the thread and an arm falls off. God forbid anybody should adopt an amendment such as this.

Here we are 7 days after I offered this amendment, and we have a circumstance where we now have a side-by-side in order to try to nullify it. We have had all kinds of dealing going on. I have not been a part of it. I don't know what the deals are. I don't know what time they were consummated. Somebody told me late last night. I am like an old Senator who served long ago. I am not part of any deal. I am not part of it. This deal is for the American people.

We are going to pass some health care legislation, and then we are going to shuffle around with our hands in our pockets, maybe thumbing our suspenders, sticking out our shined shoes, and say: We did this all right. We feel really good about it, but we couldn't do a thing about prescription drug prices. We couldn't do that. We didn't have the support because the pharmaceutical industry wouldn't let us. Oh, really? Maybe at last—at long, long last—there will be sufficient friends on this vote on behalf of the American people to say: We stand with the consumer. We are standing with the American consumers today. We like the pharmaceutical industry. We want them to produce prescription drugs. We want them to make profits. We just don't want them to charge us 10 times, 5 times, 3 times, or double what is being charged others in the world for the identical prescription drug because we don't think it is fair to the American people.

Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator has 13½ minutes.

Mr. DORGAN. Mr. President, let me at this point yield the floor. I suggest the absence of a quorum. I don't know whether the Senator from New Jersey has other speakers. I believe we have a couple other speakers who will be here. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. DORGAN. Mr. President, I ask unanimous consent that the order for the quorum call be dispensed with.

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

Mr. DORGAN. Mr. President, I ask unanimous consent that the quorum call be charged against both sides.

The PRESIDING OFFICER. Is there objection?

Mr. LAUTENBERG. Mr. President, there was an objection to having the time equally divided expressed by the Senator from Iowa before.

How much time is available on our side, Mr. President?

The PRESIDING OFFICER. The Senator from New Jersey has 7 minutes.

Mr. LAUTENBERG. Seven?

The PRESIDING OFFICER. Yes, 7 minutes.

Mr. LAUTENBERG. Mr. President, I, too, have people who want to speak to the issue. If we can equally divide the quorum call, that is all right with me. I have no objection.

Mr. DORGAN. I believe the quorum call will be momentary. We have people coming to speak. If not, I will take some additional time, as perhaps will the Senator from New Jersey. I suggest the absence of a quorum and ask unanimous consent that it be charged to all sides equally.

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

The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

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

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

Mr. DORGAN. Mr. President, I did not speak about the letter from the Food and Drug Administration. My colleagues have described this letter, which I said could have come out of a copying machine. A similar letter has come each time we consider this legislation. It is interesting to me that we export a lot of American jobs. All kinds of jobs are leaving our country. Then we import contaminated wallboard, children's toys that kill kids. And, yes, that has happened. We import contaminated pet food and contaminated toothpaste. We import 85 percent of the seafood into this country every day—85 percent of the seafood—and 1 percent is inspected, by the way. One percent of that seafood is inspected. The rest is not.

We import fruits and vegetables. I am wondering if the Food and Drug Administration is sending letters around with concern about the risk to health of fruits and vegetables and seafoods that are not inspected.

In many places, these products are produced with insecticides and various things that would not be permitted in this country. I am wondering where the FDA's letter is with respect to that.

I called the Food and Drug Administration. I talked with the head of the FDA. I said: I understand there are rumors around that you are going to send a letter here. This was 24 hours before the letter came.

The head of the FDA said: I know nothing of such a letter.

My question is, Where did the letter come from? Who prompted the letter? I think I know.

I find it interesting, I don't see anybody at the FDA sending letters here about the issue of safety on fruits, vegetables, and fish. They raise the issue of safety with respect to a drug importation bill which has the most specific and the most rigorous safety standards not only for imported drugs but for the existing domestic drug supply, the kind of safety standards that the pharmaceutical industry has objected to for many years.

Mr. LAUTENBERG. Will the Senator yield for a question?

Mr. DORGAN. Of course, I will be happy to yield.

Mr. LAUTENBERG. I know Senator DORGAN very well. He is a man of great principle and skill, I might say. But I say the list of aberrations, the lack of care about the various products—the toys, wallboards, and food—I have had a great interest in those items. It is interesting that it is being suggested by the Senator from North Dakota that is an acceptable standard and we ought to go ahead and continue it.

Mr. DORGAN. The Senator is not asking a question. I yielded to the Senator for a question. If he would truncate it, I would appreciate it.

Mr. LAUTENBERG. The question is whether, if you think that casual standard for bringing in food and other products is acceptable—

Mr. DORGAN. Reclaiming my time.

Mr. LAUTENBERG.—therefore, we ought to do the same with drugs?

Mr. DORGAN. Reclaiming my time, the answer is self-evident by the question. Of course, we would benefit from stricter standards for fish, vegetables, and fruits. That was the point I was making. But what we have done with respect to importation of prescription drugs is we have included batch lots and pedigrees and tracers that do not exist in the existing drug supply. Why? The existing drug supply does not have those provisions because they have been objected to over the years by the pharmaceutical industry.

We have put in place procedures that will make this safe. You cannot say the same thing about fruits, vegetables, and seafood, unfortunately. A lot of work needs to be done there. But we do not bring a bill to the floor of the Senate, a bipartisan group of legislators, a bill that would in any way injure or provide problems with respect to safety.

What we do is bring to the floor of the Senate legislation that dramatically enhances the margin of safety for prescription drugs. But I understand, I understand completely. If I were trying to protect, and I were the drug industry trying to protect billions, boy, I understand the exertion of effort to try to protect that.

My only point is this: I have a beef with an industry that decides they are going to overcharge the American people, in some cases 10 times more, in some cases 5, double the price that is paid in other parts of the world for the identical drug. I don't think that is fair, and I don't think we should allow it to continue. The way to prevent it is to give the American people the freedom—every European has that freedom.

Let me end with how I began. For somebody to come out here and say this is about unregulated, untested drugs is absolute sheer nonsense. It is not. We do not have to debate what words mean and what words say. That is not a debate we ought to take time to have. All we have to do is read it and then represent it accurately, which has not been the case on the floor of the Senate, regrettably.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

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

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

Mr. DORGAN. Mr. President, is it the case when a quorum call is requested it is equally charged?

The PRESIDING OFFICER. No.

Mr. DORGAN. Mr. President, I ask unanimous consent that the quorum call be equally charged on both sides. I suggest the absence of a quorum.

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

The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be dispensed with.

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

Mr. BAUCUS. Mr. President, I would like to remind us why we are here—health care reform—and why health care reform is so important. I would like to go through the costs of inaction, what the consequences are if we do not pass health care reform.

First of all, rising health care costs are wrecking the lives of Americans. In 2007, 62 percent of bankruptcies were due to medical costs. This legislation will help reduce the rate of growth of health care costs. In fact, the President's Council on Economic Advisers and the President just announced today or yesterday there will be a 1-percent reduction in national health care costs. CBO basically said this bill is deficit neutral, and it will have an effect on reducing health care costs. This bill will reduce health care costs.

A Harvard study found, in addition, when people do not have health insurance, they are more likely to be much more ill.

Harvard found every year in America lack of health insurance leads to 45,000 deaths. If Americans do not have health insurance, it leads to 45,000 deaths in our country. That is intolerable. How can we in the United States of America—we pride ourselves as the biggest, the strongest, the most moral country on the globe. How can we allow 45,000 deaths just because somebody does not have health insurance? People without health insurance have a 40-percent higher risk of death than those with private health insurance.

How does this bill affect Medicare? According to the CMS Actuary, Medicare is projected to go broke in about the year 2017. CMS has estimated this will actually extend solvency to the year 2026.

That is very important, Mr. President. It is an important message to seniors—that the Medicare trust fund solvency will be extended under this legislation for at least 9 more years, beyond 2017. I wish it were further, but that is a lot better than not extending solvency—extending solvency for that period of time.

The bill also would increase the percentage of people who have health insurance from about 83 percent to 94 percent. That, too, is no small matter.

Our legislation would reform the insurance market to protect those with preexisting conditions. It would prevent insurance companies from discriminating and capping coverage, and it would require insurance companies to renew policies as long as policyholders pay their premiums.

Let me just say a bit more, with a little more precision, about premium costs. The Centers for Medicare & Medicaid Services, the Office of the Actuary, confirmed this. They confirmed that this legislation will cover 33 million Americans who are currently uninsured and will do so while significantly reducing Medicare costs and Medicaid spending. Think of that. This legislation will cover 33 million Americans who are currently not covered at the same time reducing Medicare and Medicaid costs.

Don't take my word for it. That is the projection of the Chief Actuary of CMS. In addition, as I mentioned, the Chief Actuary says this will extend the life of the trust fund for 9 years.

Moreover, this legislation reduces the cost to seniors, to a family, by $300 by 2019. Medicare Part B premiums, according to the Actuary, will be $300 lower than it otherwise would be. The out-of-pocket costs would be, for a couple—I think it is roughly $400. That is a total of about a $700 reduction for a couple in 2019. So a reduction in Medicare Part B premium costs and a reduction in out-of-pocket costs.

Essentially, the Actuary concludes, and I will read the quote:

> The proposed reductions in Medicare payment updates for providers, the actions of the Independent Medicare Advisory Board, and the excise tax on high-cost employer-sponsored health insurance would have a significant downward impact on future health care cost growth rates.

Again, a ''significant downward impact on future health care cost growth rates.'' The Actuary says the bend in the cost curve is evident. The Actuary also concludes that in 2019 health expenditures are projected to rise by 7.2 percent with no change but 6.9 percent under the proposal. That is, under the proposal, health care costs will rise at a lower rate than they will if this legislation does not pass.

In addition, this report shows how health insurance costs for millions of Americans will reduce premiums by 14 to 20 percent for people in the individual market. Actually, that was the Congressional Budget Office that reached that conclusion and not the Actuary. The Congressional Budget Office has basically concluded that for 93 percent of Americans premiums will be lowered. For 93 percent of Americans premiums will be lower.

It is true that for those who are employed—the five-sixths of persons who now have health insurance—their premiums would not go down a heck of a lot, but they will start going down due to this legislation. For the 7 percent whose premiums are not reduced, they get a better deal. That 7 percent will have much higher quality health insurance than they now have, basically because of no more denial of care for preexisting conditions, market reform,

rating reform, no more rescissions, et cetera. So this is a very good deal.

I would like to say one word, too, on health care cost reduction. A lot of Senators have quoted an article by Dr. Gawande from The New Yorker magazine—I think it was dated June 2—explaining the phenomenon of geographic variations in this country and why health care costs are much higher in some parts of America and much lower in other parts of America, which is due mostly to the way we pay health care providers and doctors in the system, therefore explaining the basic reason there is so much waste in the American health care system.

Dr. Gawande published another article in The New Yorker a week or 2 ago, and in that article he basically says of all the ideas that have been suggested by economists, by practitioners, by providers, and people worried about the rise of health care costs in America, all of the ideas are in this legislation. They are all in here. All the ways to work to start to lower health care costs are in this legislation.

He also says the pilot projects and the demonstration projects in this legislation are good because you have to work a little bit, you have to experiment a little, you have to try this and try that to see where bundling works and see where it does not work. But the provisions are there.

We can all be quite confident that this administration is going to do its level best to make sure these projects work—that is the bundling, the moving toward quality as a basic reimbursement in the way of quantity. The administration is going to work very hard to make sure they work. I will say, too, as chairman of the Finance Committee, the committee of primary jurisdiction over these subjects, that we are going to have a lot of oversight hearings next year because it is very much in the interest of the American people to make sure this legislation works and works very well. Clearly, with aggressive oversight hearings next year we can help make sure that happens.

One other point. This bill represents a net tax cut, not a tax increase—a net tax cut for individuals, not a tax increase. Why do I say that? I say that because that is what the Joint Committee on Taxation says. What is the Joint Committee on Taxation? It is a committee, an organization in Washington that serves both the House and the Senate. It serves Republicans and Democrats. There is not one iota of partisanship in it. It is totally objective, very solid, very confident. They are the outfit we rely on when we write tax legislation.

Basically, they say by the year 2019, Americans will see a net tax cut of $40 billion, and that tax cut is equal to an average tax decrease of more than $440 per affected taxpayer. And for low- and middle-income taxpayers making less than $200,000, this cut is even greater. The average tax credit is equal to more than $640 per affected taxpayer in the year 2019.

To repeat: This bill, according to the Joint Committee on Taxation, is a net tax cut for individuals—a cut, not an increase but a cut—almost as great as the 2001 tax cut. Many of us know how great that was. This is the biggest tax cut since 2001—this legislation.

I also want to discuss a couple other points. A lot of people say: Well, gee, some of this does not take effect for several years. Let's go through what takes effect right away, in 2010. What are the provisions that take effect right away? I will read the list.

The first is—the fancy term is ''pools''—to help people with preexisting conditions get access to health insurance even before the actual denial of preexisting conditions kicks in. There is $5 billion of Federal support for higher risk pools providing affordable coverage to uninsured persons with preexisting conditions. That takes effect right away.

Second, reinsurance for retiree health benefit plans. Basically, that means there is immediate access to Federal reinsurance for employer plans providing coverage for early retirees—for ages between 55 and 64. Essentially, that means extra dollars are available for the outliers. That is a fancy term for saying the high-cost people in that age group—55 to 64.

In addition, we extend dependent coverage for young adults. Today, a young couple buys health insurance for themselves and their kids, and once the child is 21 there is no more health insurance. We raise that level to the age of 26 so that person can stay with the family and have the family's health insurance.

Moreover, this legislation requires that health insurers must provide prevention and wellness benefits but no deductibles and no cost-sharing requirements. That, too, will help quite a bit. That takes effect right away.

Moreover, right away, in 2010, the legislation prohibits insurers from imposing annual and lifetime caps. Not later but right away there is a prohibition against insurers from imposing annual lifetime dollar limits—a big problem today.

Moreover, right away, this legislation will stop insurers from nullifying or rescinding health insurance policies when claims are filed. Rescissions are a big problem today. In 2010, when this legislation passes, no more rescissions of health care policies.

Moreover, this legislation sets minimum standards for insurance overhead costs to ensure that most premium dollars are spent on health benefits, not costly administration or executive compensation and profits. We also require public disclosure of overhead and benefit spending and premium rebates. That is right away.

What about small business persons—small businessmen? This legislation offers tax credits to small businesses with low wages to make covering their workers more affordable. It takes effect in 2010, and credits of up to 50 percent of insurance premiums will be available to firms that choose to offer coverage.

I might also say there are stronger small business provisions, too, that I am quite certain will be in the managers' amendment. Greater incentives to the tune of about $12 billion to $13 billion for small businesses will be in this legislation and will also be in the managers' amendment.

Moreover, what will take effect next year, not later, is we have closed the coverage gap for the Medicare drug benefit. Basically, that means we have closed the doughnut hole—we are starting to close the doughnut hole. Seniors pay very high prices for brand-name drugs if they are in that so-called doughnut hole. We close it so that seniors don't have to pay those high prices anymore.

There is public access to comparable information, more transparency, and I could go on and on and on. There are many provisions which take effect right away and not at a later date.

Mr. President, I believe that debate is drawing to a conclusion on the four matters under consideration. We may be able to have votes as soon as 5:30.

I see my colleagues from Kansas and Iowa on the Senate floor, and I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I ask unanimous consent to use 5 minutes of Senator MCCONNELL's time—the Republican leader's time.

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

Mr. BROWNBACK. Mr. President, I thank my colleagues for this opportunity to address the Lautenberg amendment and speak in favor of the Lautenberg amendment.

I oppose the base bill. I oppose the bill overall. I have spoken a number of times in opposition to the overall bill. It is way too expensive, it cuts Medicare, raises taxes, and inserts the funding of abortion, which is something we haven't looked at in 30 years. The Hyde language has not allowed funding of abortion, and instead this does and puts it in, and I think it will result in poorer health care for a number of Americans.

But the issue I rise on today is on the Lautenberg amendment, and in support of the Lautenberg amendment. This is an amendment we have seen in this body four times previously over the last 10 years. Each time the Lautenberg amendment has passed overwhelmingly, and that is because of the safety concerns for drugs coming into the United States.

I would note that Secretary Sebelius, Secretary of HHS—Health and Human Services—who before being named to this position was the Governor of the State of Kansas for 6 years, with whom I worked over the years, through her office has stated they cannot basically certify the safety of these drugs.

There is a letter that has been gone over in some depth and length from the Food and Drug Commissioner saying that it is going to be very difficult for them to certify the safety of these drugs. Yet what the Lautenberg amendment does is it says: OK, if you can certify safety, and this is going to reduce the price, then they can be admitted.

That seems to make sense. That is why 4 times over the last 10 years this body has passed the Lautenberg amendment, or an equivalent, and I think that is appropriate.

I would also note there is a huge industry in the United States—the pharmaceutical industry—that is quite concerned about the safety and efficacy of what this bill would do in not allowing the safety of the drugs if you don't pass a Lautenberg amendment. They are very concerned about that. And toward that regard, I will read pieces of a letter sent to me by Kansas Bio. It is the Kansas Biosciences Organization. They sent this letter to me saying:

On behalf of the members of Kansas Bio, please accept this letter in opposition to Senator Dorgan's drug importation amendment to the health care reform legislation which may be voted on by the Senate. We believe that the promotion of drug importation is an extremely risky endeavor which threatens the livelihood of one of Kansas' fastest growing bioscience industry sectors—the service providers to our Nation's and our world's drug development and delivery companies.

KansasBio is an industry organization representing over 150 bioscience companies, academic institutions, State affiliates, and related economic development organizations in the State of Kansas, throughout the Kansas City region. . . . Senator DORGAN's amendment opens up the risk of allowing foreign drugs that do not have FDA approval into the United States and thereby posing significant health and safety risks to the patients.

It is signed by the president and CEO, Angela Kreps, of KansasBio.

I am ranking member on the Senate Appropriations Subcommittee on Agriculture, Rural Development, and the Food and Drug Administration, so I am keenly interested in the committee structure in this issue.

In addition, the University of Kansas in my State, in addition to having the top-ranked basketball team in the country, has the top-ranked pharmaceutical school in the country. They are a part of KansasBio and concerned about the Dorgan amendment in place. That is why they support things like the Lautenberg amendment which assure two things: that you have safety and that any value in this proposal is passed along to the consumer.

The FDA has been tasked with the responsibility of safeguarding this country's prescription drug supply and has executed that responsibility, I believe, quite well. It would be unwise for this body, then, to not value their opinions in regard to this matter. The Lautenberg amendment counts on the FDA expertise and proven track record and permits legal importation of prescription drugs into the United States only if Secretary of Health and Human Services, Secretary Sebelius in this administration, as head of the FDA, can certify to Congress that prescription drug importation will do two things: No. 1, pose no additional risk to the public health and safety; and, No. 2, result in a significant reduction in the cost of covered products to the American consumer. The safety and cost savings certification amendment would restore this language.

The Lautenberg amendment does that. This Congress must require a safety and cost savings certification from the Secretary of HHS before opening the floodgates of drug importation. Requiring this certification is the responsible way to ensure that American citizens will be protected from potentially life-threatening counterfeit, contaminated, or diluted prescription drugs.

As I mentioned, the Senate has voted on this previously four times, each time overwhelmingly adopting something like the Lautenberg amendment. As many of my colleagues may remember, the safety and cost savings certification was first signed into law when the Senate passed the Medicine Equity and Drug Safety Act of 2000. During that debate, concerns were raised by many in this body that drug importation would expose Americans to counterfeit and polluted prescription drugs. To alleviate these well-documented fears, the Senate passed this second-degree amendment then unanimously.

To date, as noted earlier, no HHS Secretary has been able to certify that drug importation will not pose a significant health and safety threat. For those reasons, I support the Lautenberg amendment.

I yield the floor.

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

The Senator from New Jersey is recognized.

Mr. LAUTENBERG. Mr. President, I think we have some time available. I wish to continue with some remarks. I thank the Senator from Kansas for his remarks and his concern also about the efficacy and the safety of drugs that might reach our citizens.

I listened carefully to the remarks of my colleague from North Dakota. He said the principal focus of our amendment is to protect the profits of the drug companies. No, I want to protect the health and well-being of American citizens. I look at an industry that has prolonged life expectancy, has made life more productive and pleasant for many whose disabilities may have them imprisoned in their homes.

We look at what has happened over the years, where treatment for conditions such as malaria, polio, smallpox were discovered, and antibiotics and chemotherapy have continued to be developed, primarily by American drug companies. Those are the companies that have the reputation for bringing the best products to market, the most carefully scrutinized, and most effective. What I want is for those companies to continue to be developing drugs that will extend wellness and will continue to improve longevity. I want these products to be available more reasonably, more cheaply—more affordably.

I had an experience in my life—people have heard me talk about this at times—whereby my father got cancer, was disabled with cancer when he was 42 years old. Our family was virtually bankrupt as a result of the cost for drugs and hospital services and physicians, so I know how costly they are. My father had cancer then, and I have seen what has happened now, with the opportunities for some optimism in situations where cancer develops. We are looking to make these drugs more available, more affordable.

The thing that strikes me, as we review where we are in the development of a new health plan or a reform of the existing health programs, and I hear the criticism coming from people who have indicated they do not support more available health products, I think about what happens when votes come about that move the health care bill along. There is absolute obstinacy that prevails with many of our friends on the Republican side.

I look at what good, proper products can do and the hope we have for childhood diseases that are so painful to see. We look for improvements in those—whether it is autism or diabetes or other conditions. We want desperately for companies in this country of ours to continue to develop drugs to treat them—or companies anywhere. But when they come to this country we have to know they are safe because there is nothing that can excuse the sacrifice of safety, for whatever discounts you might get on the product, products that, as has been noted, can kill you if they are the wrong formula or contaminated product.

Our differences between the Dorgan and Lautenberg amendments boil down to one word: safety. Knowing that when you open the bottle, that when you take the liquid, you are not doing something or your children or your loved ones are not doing something that harms their health. We owe them that feeling of security and comfort as they try to cure themselves from sickness or disease. That is what we are looking at here. I hope my colleagues will stand up and say no, don't let these products come in without the tightest scrutiny that can be developed; without the most secure process of production and shipment that can be exercised.

I yield the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask how many minutes I have remaining.

The PRESIDING OFFICER. The Senator has 15 minutes remaining.

Mr. BAUCUS. I yield 5 minutes to my good friend from Iowa who I think is

going to be speaking against my position but he is a good fellow so I think he should have 5 minutes.

Mr. GRASSLEY. This is typical of the comity of the Senate. I thank my good friend for doing that. I have a little different view on some of the things he said about taxes here. I respect him giving me some time because we don't have time on this side. It is nice, his doing that.

Republicans and Democrats are working off of the same data provided by the Joint Committee on Taxation. For some reason my friends on the other side of the aisle seem to want to read this data selectively, so I wish to look at this data. I want to stress this data is from the nonpartisan Joint Committee on Taxation. They are experts. They are nonpolitical people who tell it like it is.

My friends on the other side are correct in one thing: This bill provides a tax benefit to a small group of Americans. You can see right here that this benefit is to the people here where the minus sign is in front of the numbers. These numbers are in white.

As I pointed out previously, when you see a negative number on this chart, the Joint Committee on Taxation is telling us these people are receiving a tax benefit. This income category—the income categories where you see these negative numbers begin at zero and stretch to $50,000 for individuals and $75,000 for families. That will be $50,000 to $75,000. I give my Democratic friends credit for being right on this part of the data. But I want to show you where I disagree with them and their choosing to overlook other parts of the data, the data I will soon refer to here on this chart.

When we see negative numbers on this chart, as I have said, the Joint Committee on Taxation is telling us that there is a tax benefit. So, conversely, where there are positive numbers—this will be an example of positive numbers—the Joint Committee on Taxation is telling us these taxpayers are seeing a tax increase. Those numbers I have already pointed to begin at $50,000 for an individual and go up to $200,000 for an individual.

When we see a positive number, then, it is the reverse. The Joint Committee on Taxation is telling us these taxpayers are in fact seeing tax increases. So if we see positive numbers for individuals making more than $50,000 and we see positive numbers for families making more than $75,000, it is just this simple: We know these people's taxes are going to go up.

The Joint Committee on Taxation is telling us that taxes for these individuals, once again, for a third time, will go up under this 2,074-page Reid bill.

These individuals and families are making less than $200,000. What is significant about less than $200,000 is that this violates what the President promised in his campaign, that individuals who are middle class, under $200,000, are not going to see one dime of tax increase.

To come to any different conclusion is saying that the data on this chart—and of course the professionals at the Joint Committee on Taxation—both are wrong. To come to any different conclusion is saying the chart produced by the Joint Committee on Taxation is wrong.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. How much time remains?

The PRESIDING OFFICER. There is 11 minutes.

Mr. BAUCUS. On this side? Does anyone have remaining time?

The PRESIDING OFFICER. The Senator from Idaho has 3 minutes. The Republican leader has 3½ minutes. The Senator from North Dakota has 7½ minutes. The Senator from New Jersey has 1 minute.

Mr. BAUCUS. Mr. President, I yield myself 5 minutes.

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

Mr. BAUCUS. I would like to make it clear, essentially this legislation does several things. This is the core part of this legislation. What is it? First, this legislation very significantly reforms the health insurance industry, especially for people who individually buy insurance and also for people who buy for a small company and even buy insurance for a large company. It is insurance market reform. It stops insurance companies from, frankly, undertaking practices which are un-American; that is, denying people coverage based on preexisting conditions, denying them health insurance because they have some kind of preexisting something—that is ridiculous—or saying: You can't have health insurance because you have some other health care status or saying: Sure, we will give you a policy, then a month, 2 months later, rescind it willy-nilly or putting in restrictive limits on what the company will pay during your lifetime or what the company might pay in health insurance benefits for a year.

In addition, this legislation reforms what are called rating provisions that States have. States basically allow companies to charge whatever they want, if you are a little older compared to if you are younger, if you are a woman compared to a man. There are lots of different ways States allow insurance companies to charge based upon different categories. So, No. 1, insurance market reform. This legislation stops some outrageous practices that insurance companies practice today.

No. 2, this legislation begins to get control over health care costs. We have to start to get control over health care costs. This legislation does so. It also is deficit neutral. It does not cost one thin dime for us to enact this legislation. It is all paid for. It provides health insurance coverage. About 31 million Americans who currently do not have health insurance will have health insurance, if this legislation passes. I don't have to remind my colleagues of the importance of health insurance. Insurance market reform that lowers the cost of health care in this country, provides full coverage and, equally important, begins to put in place delivery system reforms. That is kind of wonkish, but it is one of the most important parts of this bill, starting to change the way we pay doctors and hospitals, pay based more on quality rather than quantity, start putting into effect different systems that sound kind of wonkish but will be important over 3, 4, 5 years. It is bundling, group homes. It is lowering the practice of hospitals that readmit too quickly after a patient is discharged.

There are so many reforms here. I strongly urge everyone to keep their eye on the ball. Insurance market reform in this legislation, lowering costs in this legislation, lowering taxes in this legislation, insurance coverage for 31 million Americans who today do not have it, and starting to put in place payment reforms which will help get this country on the right path so, after several years, we have a health care system we are all proud of, one that gets rid of all the waste we have in the country today. We pay $2.5 trillion a year in health care, about half public and half private. People who study this say we waste as much as $800 billion a year—not million, billion—in fraud, waste, dollars that don't go directly to health care. This legislation starts to get a handle on that. It stops all the waste. You get a better handle on fraud so after 2 or 3 years, we will have something we are very proud of. Let us remind ourselves, again, if we don't pass this legislation, we will rue the day we didn't because we will have to start all over again, 2 or 3 or 4 or 5 years from now, and the problem will be much worse. The cost for families is going to be much greater, the cost to American businesses much greater. Our budgets are going to be in much worse shape, Medicare and Medicaid. This legislation extends the solvency of the Medicare trust fund for another 9 years.

Remember the bottom line, remember the basics. Let's not get too caught up in the details of the weeds and get distracted by a lot of stuff that is not the core of this bill. The provisions I outlined are compelling reasons why this legislation must pass and why it would be so good for America.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAPO. I ask unanimous consent to use the remainder of my time as well as that of the Republican leader.

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

Mr. CRAPO. Mr. President, I would like to respond to a couple of the points made about whether this bill truly does address what the American people are asking it to address. If you ask most people in America what they want out of health care reform—and

they do want reform—they will tell you they want to see control of the skyrocketing cost of health care, particularly the cost of insurance premiums. They would like to see increased access to quality medical care. It has been said a number of times by the proponents of this legislation that this bill accomplishes those objectives, but let's look at exactly what the Congressional Budget Office has told us on the core issue; namely, what is going to happen to your insurance premiums if this bill is passed.

What the Congressional Budget Office very clearly said, which is also backed by 7, 8, 9 or 10 other studies from the private sector as well as the Joint Committee on Taxation and backed by the Chief Actuary for the Center for Medicare and Medicaid Services, is that for at least 30 percent and the most vulnerable people in America, if you are looking at whether your insurance premiums are going to go up or down, they are going to go up, not down. If you are a member of the 17 percent of Americans who get your insurance in the individual market, your insurance is going to go way up. In fact, it is going to go up by as much as 10 to 13 percent in addition to what it would have gone up without the bill. If you are someone who gets your business from small groups, from a small group market, your insurance costs are going to go up from 1 to 3 percent. If you are one of the Americans who is able to get your insurance in the large group market, then you can basically expect that the bill will have no significant impact on you. There is a possibility of a slight reduction, but the potential is, it is going to have no impact at all.

What does the bill do? For 17 percent of Americans in the individual market and for 13 percent of Americans in the small group market, it clearly makes your health care premiums go up. For those who are in the remainder of the market, it basically doesn't achieve the objective of health care reform—and at what price? We often hear we need to bend down the cost curve. As I have indicated, this legislation doesn't bend down the cost curve Americans are talking about; namely, the price of their health care or their health insurance. What does it do with regard to the Federal Government? It is going to increase the cost to the Federal Government on health care by $2.5 trillion in a massive new entitlement program. So that price curve is not bent down.

Then what are we left with? Some say the deficit will go down under this bill. There is only one way the deficit can go down under this bill; that is, if you take away the budget gimmicks, massive tax increases, and massive Medicare cuts. But I will just talk about the budget gimmicks because of a lack of time. The spending side of this bill is delayed for 4 years. The taxing and cutting Medicare side of the bill is implemented on day one. So we have 10 years of tax increases to offset 6 years of spending. I think that is the way the number was reached. You have to figure out how many years to delay the spending start before you can say there was a deficit-neutral bill. The reality is, this bill doesn't deal with any of those spending curves.

The matter we will be voting on in a few minutes is my motion that would address the tax side of the bill. All it says is: Let's change the bill to comply with the President's promise; namely, that people making less than $200,000 a year or $250,000 as a couple would not pay more taxes. What we found from the Joint Tax Committee is, 73 million Americans in that category will pay more taxes. In fact, it is not 73 million Americans, it is 73 million American households who will pay more taxes and see a tax increase under this bill and not just a small one. It is massive, hundreds of billions of dollars of new taxes that will be imposed by this bill.

In response, the proponents of this bill say: But this bill is a tax cut. The only way they can say this bill is a tax cut is by looking at the subsidy that is going to be provided as a tax cut. It is called a refundable tax credit, although three-fourths of it, 73 percent to be accurate, goes to people who do not pay taxes. Yet it is called tax relief because it is administered through the Tax Code and is described as a refundable tax credit. The CBO gets this and Americans get it. The Congressional Budget Office says these aren't tax cuts. This is spending, and it is scored that way by the CBO as it analyzes the bill. The only way you can say this bill involves these kinds of tax cuts is if you say that a provision that will simply result in the payment of a check by the Federal Government to an individual who has no tax liability to assist them with their health care costs is a tax cut. Let's accept that.

Even in that case, only 7 percent of Americans qualify for that subsidy, and the rest qualify for the tax increases. To say the President's promise was that I will not cut your taxes more or I will not increase your taxes more than I will cut someone else's taxes and, by the way, I will call a direct subsidy a tax cut, is not exactly what I think the President meant. It is not what the American people thought he meant when he said Americans making less than $200,000 or $250,000 as a family would not pay more taxes under this bill.

My proposal simply says send this bill back to the Finance Committee. They can turn it around quickly, if they want to. Have them take out the provisions that violate the President's pledge on taxes.

I retain the remainder of my time.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. I yield 3 minutes to the Senator from Ohio.

Mr. BROWN. Mr. President, I rise in support of the Dorgan amendment on reimportation. This is not about importing drugs from China or India or Mexico, where drug safety standards are not up to par. Although American companies have outsourced a lot of their manufacturing to those countries and found a lot of problems with the ingredients they import into American drugs, that is not the issue. That underscores the hypocrisy of U.S. drug companies in opposing the Dorgan amendment.

This is about importing drugs from countries such as Canada and Germany and Australia and New Zealand and Japan, countries with highly developed drug safety regimes. Patients in England and France and Germany and New Zealand and Canada have the same protections we do. I have been in drugstores in Canada just 2 hours from Toledo, less than that, and you see the same drug and the same dosage, the same packaging, the same company making them. In Canada, it is 35 to 55 percent lower than in the United States. One drug, the cholesterol-lowering drug Lipitor, is $33 in Canada, $53 in France, $48 in Germany, $63 in the Netherlands, $32 in Spain, $40 in the United Kingdom. Same packaging, same company, same dosage, same drug is $125 in the United States We pay more, even though, in most cases, these drugs are either manufactured in the United States or developed, in some cases, by U.S. taxpayers, developed certainly in the United States for Americans, but we pay two and three times more.

A 2009 Consumer Reports survey found that due to high drug prices, one out of six consumers failed to fill a prescription, one out of six consumers skipped doses.

Mr. President, 23 percent of consumers cut back on groceries. They choose between do I get my groceries or pay for this drug? Consumer after consumer will cut their pill in half and take one part today and one part the next day, which is not what their doctor says they should do. We know this is not good for Americans' health. We know this is not good for Americans' pocketbooks. We know this is not good for taxpayers. It is not good for small business. It is not good for big business, large American companies that are paying the freight, that are paying these costs. American consumers and taxpayers and businesses are suffering from these high costs.

Pharmaceutical companies hike up prices, rake in massive profits. They are one of the three most profitable industries in this Nation and have been for decades. The pharmaceutical industry, in 2008, recorded sales in excess of $300 billion, with a 19-percent profit margin. This is in a bad year—a bad year for most of us in this country, in 2008. In the last year alone, the brand-name prescription drug industry raised their prices by more than 9 percent.

I ask my colleagues to support the Dorgan amendment.

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

The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that at 6 p.m. today, the Senate proceed to vote in relation to the amendments and motion specified in the order of December 14 regarding H.R. 3590; that prior to each vote, there be 2 minutes of debate, equally divided and controlled in the usual form; that after the first vote in the sequence, the succeeding votes be limited to 10 minutes each; further, that all provisions of the December 14 order remain in effect.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from North Dakota.

Mr. DORGAN. Mr. President, some issues we deal with here in the Senate are unbelievably complicated. This one is not. This is painfully simple, the question of whether the American people should be charged and continue paying the highest prices in the world for brand-name prescription drugs—my amendment says no—from other countries in which there is a safe chain of custody that is identical to ours. The American people ought to have the freedom to shop for those lower priced FDA-approved drugs that are sold there at a fraction of the price.

I especially wish to thank Senator BEGICH from Alaska for his work. This is bipartisan, with a broad number of Democrats and Republicans working on this importation of prescription drugs bill, giving the American people the freedom to acquire lower priced drugs. Senator BEGICH has been a significant part of that effort. I want to say thanks to him for his work on this amendment.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. BEGICH. Mr. President, if I could ask a question of the Senator from North Dakota.

I say to the Senator, I appreciate his comments, and I think he is right. Of all the complexity of this bill, this seems so simple. I know when I was mayor, we worked on this issue. It seems logical for Alaska. Since we border so much of Canada, it seems logical to do what we can in this arena.

I know the Senator stated these comments before, but I think it is important for especially my viewers who are now watching from Alaska, with the 4-hour difference. But the Senator talked about the savings. There are savings to the taxpayers that are very clear, and there are savings to the consumer, which is even more significant. Can the Senator remind me what those numbers are? I think I have them. I want to be sure, as I talk about this bill.

Mr. DORGAN. Mr. President, this amendment will save $100 billion in 10 years, nearly $20 billion for the Federal Government and nearly $80 billion for the American consumers.

Mr. BEGICH. That is what this health care bill is about, not only getting good-quality care but also finding those opportunities, as we just heard one Senator talk about, bending that cost curve—I hate that term—but it is impacting the consumers in a positive way by $80 billion.

The other thing I have heard a lot about on the floor—and the Senator talked quickly about it—is the chain of control, which I drove here for 19 days with my family through Canada, and 5 days we bought some drugs when I had a cold, but I am still here. I am standing. I am healthy. Remind me of that chain of control for these drugs and where they are produced.

Mr. DORGAN. I would say to the Senator from Alaska, these prescription drugs would be able to be reimported from Australia, New Zealand, Japan, and the European countries that have identical chains of custody to our chain of custody so that there is safety.

It is also the case that we are in politics, so the floor of the Senate is the place of a lot of tall tales. I understand that. I have been in politics for a long time.

Mr. BEGICH. Yes, I have learned that as a new Member.

Mr. DORGAN. But early on, one of my colleagues said this is about untested, unregulated drugs coming from, oh, parts of the Soviet Union. That is so unbelievable. It is not describing the amendment I have offered. We are talking about a chain of custody that is identical to the United States. When that is the case—if it is the case—why would the American people not have the freedom to acquire that same drug when it is sold at one-tenth the price, one-fifth, one-third, or one-half the price? Why not give the American people that freedom?

Mr. BEGICH. The Senator from North Dakota and I have just one last question. Even though we did not ask for a colloquy, this is kind of a colloquy, and I appreciate the back-and-forth.

This is one reason I support this bill—not only today but many months ago—for all the reasons the Senator just laid out. The control is there. The protection to the consumer is there. The savings to the consumer and the taxpayer are enormous, as we deal with these issues. If there is one thing I have heard over and over through e-mails and correspondence to my office, it is: Help us save on prescription drugs.

To emphasize that point once more, to make sure I have the numbers right, over 10 years, between the Federal Government and the consumer, it is over $100 billion.

Mr. DORGAN. Mr. President, the savings is over $100 billion. Look, I want the pharmaceutical industry to do well, to make profits, to make prescription drugs. I just want fair pricing for the American people. I do not have a beef with the industry. I want them to do well. I want them, however, to give the American people a fair price because we are paying the highest prices in the world for brand-name prescription drugs, and I think it is flat out unfair. This amendment will fix that.

There is a competing amendment that nullifies it, that simply says all this is going to go away and we are done with this bill and nothing has happened to put the brakes on prescription drug prices.

I hope my colleagues will stand with me and with the American people saying: We support fair drug prices for the American people. That is what we are going to vote on in a few minutes.

I appreciate the questions from the Senator from Alaska.

Mr. BEGICH. Thank you, Mr. President. And I thank the Senator from North Dakota for allowing me these questions and again clarifying for my residents in Alaska how important this bill is. Thank you.

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

The Senator from Montana.

Mr. BAUCUS. Mr. President, parliamentary inquiry: The order that was just entered provided for 2 minutes, equally divided, before, I suppose, the vote on each of the amendments. Is that in addition to or is that a part of the time that has been allocated to Senators?

The PRESIDING OFFICER. In addition to.

Mr. BAUCUS. I thank the Chair.

The PRESIDING OFFICER. The Senator from Montana has 5 minutes remaining.

Mr. BAUCUS. So, Mr. President, if the Senator from Montana wishes to speak on his amendment, he has 5 minutes, plus 2 minutes.

The PRESIDING OFFICER. Five minutes plus 1 minute.

Mr. BAUCUS. Excuse me. The time is equally divided. Thank you.

Mr. President, I just want to make it as clear as I can that the Congressional Budget Office essentially says that premiums will go down for about 93 percent of Americans. I say that because I think my good friend from Idaho was leaving a different impression.

But let me just summarize what CBO says. I would put a chart that CBO provided in the RECORD, but under the Senate rules we cannot put charts in the RECORD. So I am just going to summarize what this chart says.

OK. Seventy percent of Americans will get their health insurance in what is called the large group market. That is people who work for larger employers—70 percent. CBO said for that 70 percent of Americans, premiums will go down a little bit. It will be about a 3-percent reduction in premiums.

The next group of Americans getting health insurance are in what is called the small group market. Those are people in small companies, small businesses, primarily. That is where 13 percent of Americans get their insurance. CBO says for that 13 percent, maybe the premiums will go up between 1 percent or down 2 percentage points overall. But for those folks, those small businesspeople who get tax credits—

and there are some very significant tax credits in this bill, and I think it will be even more significant when the managers' amendment is out—CBO says, even with modest tax credits, those premiums will go down 8 to 11 percent.

That is, for 13 percent of Americans who have insurance, their premiums will go down 8 to 11 percent, among those who have credits.

Let's look at what is called the nongroup market, the individual market. That is 17 percent of Americans. For those folks, if you compare their current insurance with what they will have in the future, those premiums will go down 14 to 20 percent—down 14 to 20 percent—according to CBO.

In addition, though, CBO says that persons who have tax credits—we are talking now about the individual market—those people will find, on average, their premiums will go down 56 to 59 percent. Remember, 17 percent of Americans buy insurance individually. Of that 17 percent, 10 percent, because of tax credits in this bill, will find their premiums go down 56 to 59 percent.

The 7 percent that are remaining—remember I started off by saying for 93 percent, there will be a reduction. The 7 percent remaining will find that because of better benefits, their premiums will go up 10 to 13 percent, but they will have a lot better benefits. They will have a lot higher quality insurance than they have today. Frankly, my judgment is, the higher quality insurance they have, because of this legislation, will outweigh the increase in the premiums.

But anyway, for 93 percent, premiums will go down.

AMENDMENT NO. 3183

Mr. President, let me speak a little bit on my amendment which, as I understand it, is going to be the first amendment voted on.

I remind my colleagues that the underlying legislation is a tax cut bill. It cuts taxes. It cuts taxes very significantly. Over the next 10 years, for example, this bill will provide Americans with a $441 billion tax cut to buy health insurance—$441 billion in tax credits to buy health insurance. Credits are tax reductions.

In the year 2017, taxpayers who earn between $20,000 and $30,000 a year will see an average tax cut of nearly 37 percent. These are people who have a hard time making ends meet. People who earn between $20,000 and $30,000 will see an average tax cut of 37 percent. That is according to the Joint Committee on Taxation.

In addition, 2 years later, the average taxpayer making less than $75,000 a year will receive a tax credit of $1,500. Just to repeat, the average taxpayer making less than $75,000 a year will receive a tax reduction—a tax credit—of more than $1,500.

The Crapo motion to commit is really an attempt to kill health care reform. It is, thus, a plan to keep Americans from getting these tax cuts. I think we want Americans to get these tax cuts. If the Crapo motion is successful, Americans will not get any of these tax cuts. We want them to. The underlying bill gives Americans these tax cuts. Therefore, I think we should reject this procedural maneuver designed to kill the tax cuts in this health care bill.

That is what my side-by-side amendment says—that is going to be the first amendment voted on—and that is, let's vote to keep our current tax cuts. I urge a positive vote on my amendment and a ''no'' vote on the Crapo motion, which eliminates the tax cuts, which is not what I think most Americans want. So I urge my colleagues to vote for the side-by-side amendment.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Under the previous order, there will be 2 minutes of debate equally divided prior to a vote on the Baucus amendment.

Who yields time?

The Senator from Mississippi.

Mr. COCHRAN. Mr. President, the legislation that we are discussing today, the Patient Protection and Affordable Care Act, could have a profound impact on the United States for decades to come. I am especially concerned about the tax implications of the legislation. We need to take a thorough look at these tax provisions before approving this legislation.

It is plain to see that if you have insurance, you get taxed; if you don't have insurance, you get taxed; if you need prescription drugs, you get taxed; if you need a medical device, you get taxed; if you have high out-of-pocket health expenses, you get taxed. Everyone gets taxed under this proposal.

This legislation also changes the core principle of Social Security and Medicare financing, a model called ''social insurance.'' Since Social Security was created in the 1930s and the Medicare Program in 1965, payroll tax revenues have been dedicated to financing these programs. In current tax law, all funding from the Medicare payroll tax finances the Medicare Program. This legislation proposes to increase the hospital insurance portion of the payroll tax on wages from 1.45 percent to 1.95 percent and uses the revenues to fund programs outside of Medicare. If this proposal becomes law, future Congresses will have the ability to take payroll tax revenues and use them for highways or defense or other nonsocial insurance spending. This will be a serious precedent, a long-term game-changer in how we finance our government, and I do not think it is wise to do this today.

Additionally, individuals who fail to maintain government-approved health insurance coverage would be subject to a penalty of up to $2,250 in 2016. This individual mandate tax is regressive and will largely be strapped on the backs of those who can least afford such a penalty.

Analysis by the Joint Committee on Taxation reveals that while a relatively small group of middle-class individuals, families, and single parents may benefit under this bill, a much larger group of middle-class individuals, families and single parents will be disadvantaged. According to the analysis by the Joint Committee on Tax, this legislation increases taxes by a 3 to 1 ratio on people making less than $200,000 a year, in other words for every one individual or family that gets the tax credit, three middle-income individuals and families are taxed. Roughly 42 million individuals and families, or 25 percent of all tax returns under $200,000 will, on average, pay higher taxes under this bill, even with the tax credits factored in.

There are only about 17,000 Mississippi tax filers who earn more than $200,000, so we are looking at over 2.5 million people who earn less than $200,000 and could easily be forced to pay higher taxes. This legislation will affect a large majority of our tax base.

Tax spending as proposed in the legislation before us provides credits for health insurance to individuals and families between 100 percent and 400 percent of the Federal poverty level, FPL. For example, a family at 100 percent of the Federal poverty level can pay no more than 2 percent of their income on premiums, and the government would pick up the rest of the cost. Although this furthers the goal of trying to get everyone insured, only 7 percent of Americans will be eligible for a tax credit and 91 percent of Americans will experience an increase in taxes. This hardly seems like a solution.

The health care industry, including many small businesses in my state, would be subject to fees imposed by this legislation. Health insurance companies that administer a self-insured policy on behalf of employers would be subject to fees imposed on the industry. This $6.7 billion annual fee will undoubtedly be passed on to consumers.

This legislation imposes a nondeductible $2.3 billion fee on manufacturers of prescription drugs, which is an example of yet another fee that will be passed on to consumers.

Medical device manufacturers will be on the hook for $2 billion in annual fees. Again, this will be passed on to consumers.

Of additional concern is the ''free-rider'' penalty for employers with more than 50 employees that do not offer health insurance coverage. These employers would be required to pay a fee for each employee. Businesses that pay any amount greater than $600 to corporate providers of services would have to file an information report with the IRS, adding further regulatory burdens on business and on an agency that does not traditionally deal in health care.

According to a recent study, taxes in this proposal will place approximately 5.2 million low-income workers at risk of losing their jobs or having their hours reduced. An additional 10.2 million workers could see lower wages and

reduced benefits. Why would we want to put people at risk of losing their jobs? A small business owner in my State told me that 8 percent of his income goes to pay for health insurance for his employees. If this amount is increased, he will be forced to reduce the size of his staff. Why would we want to hurt small businesses at a time like this?

We all remember President Obama's campaign promise that he would not raise taxes on families earning less than $250,000 a year. The Joint Committee on Taxation conducted an analysis that shows that in 2019—when the bill is in full effect—on average individuals making over $50,000 and families making over $75,000 would have seen their taxes go up under this legislation. In other words, 42 million individuals and families earning less than $200,000 would pay higher taxes.

Arguably millions more middle-class families and individuals could be hit with a tax increase from the health care industry ''fees'' or taxes proposed. According to testimony of the Congressional Budget Office before the Senate Finance Committee, these fees would be passed through to health care consumers and would increase health insurance premiums and prices for health care-related products. If the President signs this legislation in its current form, he would break his pledge not to raise taxes on people making less than $250,000 a year.

My distinguished friend from Idaho, Senator CRAPO, offered an amendment in the Senate Finance Committee markup providing that ''no tax, fee or penalty imposed by this legislation shall be applied to any individual earning less than $200,000 per year or any couple earning less than $250,000 per year.'' The amendment was rejected.

Small businesses in my State do not support this legislation. With unemployment at a 26-year high and small business owners struggling to simply keep their doors open, this kind of reform is not what we need to encourage small businesses to thrive. Small businesses need reform that will lower insurance costs. They need a bill that will decrease the overall cost of doing business. If a bill increases the cost of doing business or fails to reduce costs, then the bill fails to meet its intended goal of reigning in health care costs.

I would submit that the bill fails to lower national health expenditures; it fails to lower the amount of money the federal government spends on health care; and it does not bend the cost curve of rapidly increasing national health care costs. If we were running a large company, this would be an unsuccessful business proposal.

In Mississippi, we could insure a majority of the uninsured if we enrolled all eligible children in the State Children's Health Insurance Program: If more small businesses offered health insurance, and if people who could afford health insurance purchased health insurance, this would be reform.

Mr. President, I would like to see our Nation's health system reformed, but these reforms cannot be on the backs of individuals and businesses that we need to succeed. Reform should not add to the already high costs of doing business.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAPO. Mr. President, I will just take 1 minute on this, and then I think we will probably be ready to vote.

Again, I think there are two contrasting amendments here. The Senator from Montana has indicated that my motion, which would simply ask the Finance Committee to make this bill comply with the President's pledge, would somehow kill the bill—that is not at all true—and, secondly, that it would stop the tax relief in the bill that the Senator from Montana has identified, the refundable tax credits. The bottom line is, my amendment does not even address the refundable tax credits. They remain in the bill.

All my amendment does is say: Let's have the President's pledge to the American people honored in this legislation. Let's take out the taxes that 73 million American households will pay under this legislation—hundreds of billions of dollars of new taxes.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator's time has expired.

The Senator from Montana.

Mr. BAUCUS. Madam President, essentially, the Crapo motion to commit the underlying bill, the pending bill, is to the Finance Committee to take out all the tax cuts. That is what it is, so I oppose it.

I urge Senators to vote for my amendment, which is a sense of the Senate that the Senate should reject such procedural motions, basically, because we want to keep the tax cuts that are in this bill.

Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Indiana (Mr. LUGAR).

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

The result was announced—yeas 97, nays 1, as follows:

[Rollcall Vote No. 375 Leg.]

YEAS—97

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

NAYS—1

Nelson (NE)

NOT VOTING—2

Byrd Lugar

The PRESIDING OFFICER. On this vote, the yeas are 97, the nays are 1.

Under the previous order, requiring 60 votes for the adoption of the amendment, amendment No. 3183 is agreed to.

Mr. BAUCUS. Madam President, I move to reconsider the vote, and I move to lay that motion on the table.

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

MOTION TO COMMIT

The PRESIDING OFFICER. Under the previous order, there will now be 2 minutes of debate equally divided prior to a vote in relation to the Crapo motion to commit.

Mr. CRAPO. Madam President, this is a very simple vote we are going to have. This is a vote that will correct the bill to comply with the President's promise not to tax anyone who makes under $200,000 as an individual or $250,000 as a family.

I think the vote we just had was a unanimous vote for it. It said not to take tax relief out of the bill. We have had plenty of debate about tax relief—whether it is in the bill or not in the bill. This motion says let's fix the bill and take out the hundreds of billions of dollars of taxes that will fall squarely on the middle class.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Madam President, the Crapo motion to commit is an attempt to kill health care reform. If it succeeds, we will keep 31 million Americans from getting health care coverage. If it succeeds, it will keep Americans from getting the tax cuts in the bill. If the motion succeeds, over the next 10 years, Americans will get $441 billion less in tax credits to buy health insurance.

I urge that we not vote in favor of the Crapo motion, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

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

The result was announced—yeas 45, nays 54, as follows:

[Rollcall Vote No. 376 Leg.]

YEAS—45

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

NAYS—54

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

NOT VOTING—1

Byrd

The PRESIDING OFFICER. On this vote, the yeas are 45, the nays are 54. Under the previous order requiring 60 votes for the adoption of this motion, the motion is withdrawn.

AMENDMENT NO. 2793, AS MODIFIED

The PRESIDING OFFICER. Under the previous order, there will now be 2 minutes of debate equally divided prior to a vote in relationship to amendment No. 2793, as modified, offered by the Senator from North Dakota, Mr. DORGAN.

The Senator from North Dakota.

Mr. DORGAN. Madam President, this amendment is about fair pricing for prescription drugs for the American people. A colleague of mine just came up to me and said: My daughter takes Nexium. It costs her $1,000 a month. I said: I happen to have a chart about Nexium here. This illustrates better than I know how to illustrate the difference in pricing.

Here is what Nexium costs: $424 worth of Nexium in the United States is sold for $40 in Great Britain, $36 in Spain, $37 in Germany, $67 in France. If you like this kind of pricing where the American people pay the highest prices in the world for prescription drugs, if you like this kind of pricing, then you ought to vote against this amendment. But this amendment is bipartisan—Republicans and Democrats. Over 30 Members of this Senate have supported this approach, saying let's provide fair pricing for a change for the American people.

We should not be paying the highest prices in the world for prescription drugs. All I ask is that you support this amendment to give the American people the opportunity for fair pricing for a change.

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

The Senator from New Jersey.

Mr. MENENDEZ. Madam President, I rise to oppose the Dorgan amendment. Let's be clear, there are those who want to deminimize safety. But the one entity in this country that is responsible for the food and drugs is the FDA, and Commissioner Hamburg has mentioned in her letter all of the potential risks of the Dorgan amendment.

Secondly, we have heard about the European Union as an example why we should permit reimportation. What did we hear from the European Community last week? In 2 months, they seized 34 million fake tablets at customs points in all member countries, and this was beyond their greatest fears.

Thirdly, how do we create affordability? By closing the doughnut hole. And this amendment will not do that, it will undermine that.

And finally, Senator LAUTENBERG's amendment, which comes up after this amendment, is the one that permits reimportation but takes care of the safety issues that the FDA has said are critical.

We want to make sure when you buy Nexium that what you get is the substance and the quality and the quantity that you want, not something less that can undermine your health care. Vote against the Dorgan amendment.

Mr. DORGAN. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to the amendment. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD), is necessarily absent.

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

The result was announced—yeas 51, nays 48, as follows:

[Rollcall Vote No. 377 Leg.]

YEAS—51

Alexander	Corker	Harkin
Begich	Cornyn	Hutchison
Bennet	Crapo	Johanns
Bingaman	DeMint	Johnson
Bond	Dorgan	Klobuchar
Boxer	Feingold	Kohl
Brown	Feinstein	Leahy
Coburn	Franken	LeMieux
Collins	Graham	Lincoln
Conrad	Grassley	McCain
McCaskill	Risch	Stabenow
McConnell	Sanders	Thune
Merkley	Sessions	Udall (NM)
Murkowski	Shaheen	Vitter
Nelson (NE)	Shelby	Webb
Nelson (FL)	Snowe	Wicker
Pryor	Specter	Wyden

NAYS—48

Akaka	Durbin	Levin
Barrasso	Ensign	Lieberman
Baucus	Enzi	Lugar
Bayh	Gillibrand	Menendez
Bennett	Gregg	Mikulski
Brownback	Hagan	Murray
Bunning	Hatch	Reed
Burr	Inhofe	Reid
Burris	Inouye	Roberts
Cantwell	Isakson	Rockefeller
Cardin	Kaufman	Schumer
Carper	Kerry	Tester
Casey	Kirk	Udall (CO)
Chambliss	Kyl	Voinovich
Cochran	Landrieu	Warner
Dodd	Lautenberg	Whitehouse

NOT VOTING—1

Byrd

The PRESIDING OFFICER. On this vote, the yeas are 51, the nays are 48. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is withdrawn.

AMENDMENT NO. 3156

Under the previous order, there will now be 2 minutes of debate, equally divided, prior to a vote in relation to amendment No. 3156, offered by the Senator from New Jersey, Mr. LAUTENBERG.

Mr. LAUTENBERG. Madam President, this is a simple solution to a complicated problem. My amendment contains the Dorgan amendment. The work done by our friend from North Dakota is significant. But what it did not have is a guarantee, as much as possible, that the product was safe; that there were no counterfeits, that there were no mixtures of things that might not work well with other drugs.

My amendment adds a simple requirement that imported drugs be certified as safe by the Health and Human Services Secretary. I hope we will be able to pass this, which will include the Dorgan amendment, to make sure the products that get here are safe, no matter what the price will be. If it is not safe, it is worthless. We want to be sure every product that reaches our shore is safe to take and will be sold at a more reasonable cost.

Mr. BAUCUS. Madam President, I have long supported measures that allow Montanans to buy safe and effective drugs from foreign countries. This is why I support the Lautenberg amendment.

Currently, the Food and Drug Administration is required to review the safety and effectiveness of domestically produced drugs. FDA is also required to ensure the safety and effectiveness of legally imported drugs. Through FDA's robust inspection and other regulatory compliance activities, consumers can have a high degree of confidence in the quality of the drugs.

The Lautenberg amendment allows importation of drugs manufactured outside the United States and includes

numerous protective measures in addition to these activities. These measures address the health and safety risks of importing foreign drugs.

Most importantly, it requires the Secretary of Health and Human Services to certify that the imported drugs do not pose any additional risk to the public's health and safety and create savings for American consumers.

With recent increased awareness of potentially dangerous food and drug products, it is more important than ever to protect American consumers.

This amendment ensures that consumers are protected from the risk of unsafe drugs. And it ensures Americans have access to consistent, reliable medicines.

The PRESIDING OFFICER. The time of the Senator has expired. Who yields time in opposition?

The Senator from North Dakota?

Mr. DORGAN. Madam President, we have all seen this movie before. We have had these votes before. All I say is this: The pharmaceutical industry flexes its muscles and defeats an attempt for fair prescription drug prices for the American people so we can keep paying the highest prices in the world. And then there is another amendment offered that makes it seem like something is being done when, in fact, nothing is going to be done, nothing will change.

Do not vote for this amendment and go home and say you have done something about the price of prescription drugs because your constituents will know better. This amendment does nothing. If you believe, at the end of the evening, we should do nothing, by all means vote for it. Don't count me in on that vote.

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

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment. The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

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

The result was announced—yeas 56, nays 43, as follows:

[Rollcall Vote No. 378 Leg.]

YEAS—56

Akaka	Casey	Kaufman
Alexander	Chambliss	Kerry
Barrasso	Cochran	Kirk
Baucus	Cornyn	Landrieu
Bayh	Crapo	Lautenberg
Bennett	Dodd	LeMieux
Bond	Durbin	Lieberman
Boxer	Ensign	Lincoln
Brownback	Enzi	Lugar
Bunning	Gillibrand	Menendez
Burr	Hagan	Mikulski
Burris	Hutchison	Murkowski
Cantwell	Inhofe	Murray
Cardin	Isakson	Nelson (NE)
Carper	Johnson	Reed
Reid	Schumer	Udall (CO)
Risch	Shelby	Voinovich
Roberts	Specter	Warner
Rockefeller	Tester	

NAYS—43

Begich	Gregg	Pryor
Bennet	Harkin	Sanders
Bingaman	Hatch	Sessions
Brown	Inouye	Shaheen
Coburn	Johanns	Snowe
Collins	Klobuchar	Stabenow
Conrad	Kohl	Thune
Corker	Kyl	Udall (NM)
DeMint	Leahy	Vitter
Dorgan	Levin	Webb
Feingold	McCain	Whitehouse
Feinstein	McCaskill	Wicker
Franken	McConnell	Wyden
Graham	Merkley	
Grassley	Nelson (FL)	

NOT VOTING—1

Byrd

The PRESIDING OFFICER. On this vote the yeas are 56, the nays are 43. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is withdrawn.

The Senator from Texas.

MOTION TO COMMIT

Mrs. HUTCHISON. Mr. President I have a motion at the desk, and I ask that it be brought forward.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Texas [Mrs. HUTCHISON] moves to commit the bill H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes to align the effective dates of all taxes, fees, and tax increases levied by such bill so that no such tax, fee, or increase take effect until such time as the major insurance coverage provisions of the bill, including the insurance exchanges, have begun. The Committee is further instructed to maintain the deficit neutrality of the bill over the 10-year budget window.

Mrs. HUTCHISON. Mr. President, this is a motion that Senator THUNE and I are putting forward. It is a very simple motion. A lot of people don't realize that the taxes in the bill we are discussing actually start in about 3 weeks. They start in January of 2010. The effect of the bill, whatever the proposals are going to be in the bill, whatever programs are available, will not come into play until 2014. The taxes will start this next year, and they will be paid for 4 years before any of the programs the bill is supposed to put forward will be there. The motion Senator THUNE and I put forward merely says that taxes start being collected when the bill is implemented. So whatever programs are being offered to the people, whatever insurance programs, whatever kinds of benefits there might be in the bill would start at the same time as the taxes start. So you are not going to be paying taxes before you have any options that you would be able to take in this bill.

It is simple. It is clear. We believe that if you pay taxes for 4 years before you see any of the programs in this bill, the American people can't be sure there will ever be a program, because there will be intervening Congresses and intervening Presidential elections that will occur before this bill is designed to start in 2014. We have congressional elections in 2010. We have a Presidential election plus congressional elections in 2012. And 2 years following that, 2014, is when this bill will be implemented.

I hope everyone will look at this motion and support the amendment we are putting forward. It is a motion to commit the bill to fix this issue, that America should not be looking at higher drug prices, higher medical device prices, and higher costs of insurance, all of which are the first taxes that will take effect.

Let's walk through it. Starting next year in January, 3 weeks from today, there will be $22 billion in taxes on prescription drug manufacturers that will start. The price of prescription drugs, aspirin, anything that people take will go up because the drug manufacturers are going to start paying a tax. There is $19 billion in taxes on medical device manufacturers. So medical devices we use, hearing aids, things we use to treat ailments will be taxed to the tune of $19 billion next January. There is $60 billion on insurance companies starting next month. That is about $100 billion in taxes that start in about 3 weeks. So the insurance companies have probably already priced in the negotiations that they are having now with people about their insurance premiums. I am sure they realize that they are going to have to be locked in for a year or two or three and, therefore, these rises in insurance premiums are probably part of this bill we are dealing with right now. And $60 billion will be passed on to every person who has health care coverage right now.

Here we are, health care reform that is supposed to bring down the price of health care so that more people can afford it. And what is the first thing we do? It is not to offer a plan. It is not to offer any kind of program that would help people who are struggling right now because they don't have insurance. It is certainly not going to help people struggling to pay their prescription drug prices. We are going to raise the price by taxing the manufacturers of drugs, of medical devices, and the companies that are giving insurance today.

It is time that we talk about the high taxes in this bill. What we are going to talk about in the Hutchison-Thune proposal, the motion to commit, is to say at the very least, the least we can do is not ask people to pay taxes for 4 years when you are going to have three intervening congressional elections before this bill takes effect. Things could change mightily. All these taxes that are going to go into place might never bring forward the proposals that are in the underlying bill.

In 2013, 1 year before the bill is to take effect, the taxes on high benefit plans go into effect. What is a high benefit plan? A high benefit plan is one that is a good plan. Many unions have these, and many people who work for

big corporations have everything paid for. They have all of the employer regular, in the order that most companies do, payments, but they also allow in these plans to have most of the deductibles also paid for. They are very good plans. This bill will excise for those plans $149 billion, cut it right out and have an excise tax on those good plans, $149 billion. That starts in 2013. That is 1 year before the bill takes effect.

In 2013, 1 year before there is any new plan put forward, those who have very good coverage—whether it be someone who works for a big company or whether it is a union member—will start getting a 40-percent tax on that benefit. So all of the things that have been negotiated are going to have a big 40-percent tax. That starts in 2013.

In addition, in 2013, 1 year before the bill takes effect, there is a limitation put on itemized deductions for medical expenses. Today, if you spend more than 7.5 percent of your income on medical expenses, you get to deduct everything over that. So if you have a catastrophic accident or you have a very expensive disease to treat or you are in a clinical trial—something that is expensive—if you go above 7.5 percent of your income, you can deduct that. In 2013, under the bill that is before us, you would have to spend 10 percent of your income before you could deduct those expenses. That is another $15 billion that will be collected in taxes that are not collected today.

The new Medicare payroll tax, which impacts individuals who earn over $200,000 or couples who earn $125,000 each, would take effect in 2013. That is $54 billion in taxes.

These are all the taxes that take effect before the bill does, before there is any plan offered. You would have the tax that starts next month on insurance companies, pharmaceutical companies, and medical device companies. Then, in 2013, you would have a tax on high-benefit plans, a 40-percent tax on that plan. Then, in 2013, the itemized deductions will not be allowed until you have paid 10 percent of your salary in medical expenses. Then there is the Medicare payroll tax, which is going to impact individuals. All of this is before there is a program in place.

In 2014, when the bill does come forward so there are plans to be offered to people, then you start the mandates on employers and the taxes if people are not covered. So you have $28 billion in taxes on employers that start in 2014. These are the employers who cannot afford to give health care to their employees or they do not give the right kind of health care to their employees, so it is not the right percentage, and if it is not the right percentage, then the employer pays a fee of $750 to $3,000 per employee. That is their fine.

Then there is the tax on individuals who do not have health insurance, and that is $750 per adult.

My colleague from South Dakota and I will certainly want to spend more time talking about this and hope very much that our colleagues will also. I do not think this is what the American people thought they would be getting in health care reform. Of course, what we would hope the American people would get in health care reform would be lower cost options that do not require a big government plan. They would not require big taxes. They would not require big fees. If we had a lowering of the cost, by allowing small businesses to have bigger risk pools, that would not cost anything. It would allow bigger risk pools that would provide lower premiums and employers would be able to offer more to their employees.

Most employers want to offer health care to their employees. It is just a matter of the expense. The bill we are debating now is going to put more expenses and burdens on employers, at the time when we are asking them to hire more people to get us out of this recession.

Everywhere I go in Texas, when I am on an airplane, when I am in a store, a grocery store—I have not been able to do any Christmas shopping, I must admit, so I have not been in a department store, but nevertheless I do go to the grocery store—everyone who I am talking to is saying: I can't afford this. What are you all doing? And I am saying, of course: Well, we are trying to stop this because we agree with you that small businesspeople cannot afford this.

I was a small businessperson. I know how hard it is because we do not have the margins of big business, and it is very hard to make ends meet when you have all the mandates and the taxes, and when you are trying to increase your business and hire people, which is what we want them to do. You cannot do it if you are burdened with more and more expenses, as this bill will do.

What Senator THUNE and I are doing is making a motion to commit this bill back with instructions, to come back with the changes that will assure that when the implementation of this bill starts, that will trigger whatever programs are in the bill at the same time as whatever taxes and fees are going to be in this bill.

I would hope there would be fewer taxes and fees. But whatever your view is on that issue, it is a matter of simple fairness that you would not start the taxes before you start the implementation of the program. It would be like saying: I want to buy a house, and the realtor says: Well, fine, you can start paying for the house right now, and in 4 years you will be able to move in. The house might be stricken by lightning. It might fall apart. It might blow up. It might have a fire. And that is exactly what could happen in this bill.

This bill may not make it for 4 years, when people see what is in it. There will be elections, and I cannot imagine we would establish a policy of taxing people for 4 years, raising costs, leading down this path that will eventually go to a public plan that will end up doing what was originally introduced in the bill; and that is, to end up with one public plan. It will take a little longer the way the bill is being reconfigured, but it is going to end up in the same place, unless we can stop it by showing people that the mandates and the taxes are not good for our economy and they are not good for the health care system we know in this country.

We have choices in this country. We have the ability to decide who our doctor is and what insurance coverage we want, whether we want a high deductible or a low deductible. That is not a choice that should be taxed. We should not have someone tell us what procedures we can have. We should have the option of deciding that for ourselves with our doctors. That is what we want in health care reform. But that is not what is in the bill before us.

I hope we can discuss the Hutchison-Thune motion to commit. We are going to work to try to make sure everyone knows we want fairness in this bill and that people know what is in it. I hope we will get whatever the new version of the bill is very soon so we will have a chance to see if maybe there are some changes that are being made. But in the bill before us, the taxes start next month, and the bill is implemented in 2014. On its face, that is fundamentally unfair. I hope our motion is adopted so we can change it.

Mr. President, I yield the floor.

Mr. KOHL. Mr. President, today I would like to talk about health care costs. We began this endeavor to fix our broken health care system a year ago for two reasons: to move toward universal coverage, and to reduce the unacceptably high cost of health care that is threatening to ruin our country.

It is vital that in our quest to cut costs, we do not leave money on the table that could be going back into the pockets of the American people. This process is not over and while we still have time, we need to more strongly address the rising costs of prescription drugs. The cost of brand-name drugs rose nine percent last year. That is an unprecedented, unacceptable hike. In contrast, the cost of generic drugs fell by nearly nine percent over the same time period.

For years, we have tried to make it easier for Americans to have access to affordable drugs. We have worked to ease the backlog of generic drug applications at the FDA. We support comparative effectiveness studies and academic detailing to diminish the influence of brand-name drug manufacturers. And we must continue to break down the barriers to help generic drug companies get their products on the market.

Therefore it is imperative that we pass legislation to fight the backroom deals between brand name drug companies and generic drug companies that keep generics off the market and out of reach for consumers. The Kohl-Grassley amendment to stop what we call

these ''reverse payments'' is based on a bill that was passed with bipartisan support by the Judiciary Committee last month, and I thank Senator GRASSLEY for working together with me on it.

Let me be clear about what these deals are: brandname drug companies pay generic drug companies—their competition to not sell their products. The brandname drug companies win because they get rid of the competition. Generic drug companies win because they get paid without having to manufacture a product. And consumers lose because they have been robbed of a competitive marketplace.

How much do American consumers lose in these backroom deals? Thirty-five billion dollars over 10 years, according to the Federal Trade Commission. And the Congressional Budget Office estimates these anticompetitive deals cost the Federal Government nearly $2 billion on top of that, because we end up paying more for branded drugs through Medicare and Medicaid. We cannot afford to leave this money on the table, and our bill—which we hope will be included in the final health reform legislation—will make sure we do not.

We are pleased that the current bill includes a provision that Senator GRASSLEY and I hope will slow the rising cost of drugs and medical devices. Our policy aims to make transparent the influence that industry gifts and payments to doctors may have on medical care. As we look to reform the health system, it is imperative that every dollar is spent wisely.

In closing, I urge my colleagues to support my amendment to end these collusive drug company settlements and to find additional ways to reduce the cost of this bill. This proposal would save billions of dollars and reduce consumer costs by billions more. This is what we said we would do, and this is what we must do.

Mr. JOHNSON. Mr. President, I rise today to recognize that the rising health care costs plaguing our health care system are disproportionately harming small business in South Dakota and across the Nation. Over the last decade, health care costs have been rising four times faster than wages, eating into the profits of small businesses and the pocketbooks of families. Many small businesses avoid hiring new employees because the cost of providing benefits is too great, and in some cases are forced to lay off employees or drop health care coverage entirely.

A small business owner in northeastern South Dakota shared with me the impact of rising health care costs on his business. He cited a strong conviction and moral obligation to provide his employees and their families with benefits, including quality, affordable health insurance. Despite his best intentions, rising health care costs are threatening his ability to maintain those benefits.

As the employees of this small business aged and used more of their health benefits, the insurance company steadily raised rates 10 to 20 percent each year. When the rates were affordable the small business owner paid the full cost of premiums, but has since been forced to shift more and more of the costs onto his employees. If rates continue to rise, he is worried he will no longer be able to afford to offer any coverage.

And he has concrete cause for concern. Current trends paint a bleak picture of future health care costs for all Americans, but they have particular implications for small businesses. In 2000, employer-sponsored health insurance in the large group market for a family in South Dakota cost on average $6,760. In 2006, the same family health insurance plan cost $9,875. That is a 72-percent increase in 6 years and, unless action is taken to alter this unsustainable course, it is projected this same coverage will cost $16,971 in 2016. Because they lack bargaining leverage, small businesses pay on average 18 percent more than larger businesses for the same health insurance. Despite their best intentions to provide quality, affordable benefits to their employees, the unsustainable trends in our current health care system have already forced many small businesses to make tough decisions.

The Senate health care reform bill addresses the main challenges facing small businesses—affordability and choice. The Patient Protection and Affordable Care Act will increase quality, affordable options in the small group market. The Small Business Health Options Program, SHOP, Exchange will give small businesses the buying power they need to get better deals and reduce administrative burdens. And small businesses providing health insurance to their employees will be eligible for a tax credit to improve affordability. The bill will also end the discriminatory insurance industry practices in the small group market of jacking up premiums by up to 200 percent because an employee gets sick or older, or because the business hired a woman.

The Senate health reform bill will give a new measure of security to those with health insurance and extend this security to more than 30 million Americans who are currently uninsured. It will lower premiums, protect jobs and benefits, and help small businesses grow.

Mr. GRASSLEY. Mr. President, yesterday afternoon, a few of my friends on the other side made some assertions about congressional history, fiscal policy, and the role of bipartisan tax relief for the period of 2001–2006. The speakers were the distinguished junior Senators from Vermont, Ohio, and Minnesota. They are all passionate Members. They are articulate voices of the progressive, as they term it, or very liberal wing, as those of us on this side term it, portion of the Senate Democratic Caucus.

I respect the passion they bring to their views. But, as one of them has said frequently in his early months of Senate service, we are entitled to our opinions, but not entitled to our own facts. I couldn't agree more with that notion. In order to insure an intellectually honest standard of debate, both sides need to correct the record when they feel the other side has misstated the facts. It is in that spirit that I respond today.

I won't take this time to debate the merits of the surtax that they propose as a substitute revenue raiser in this bill. That can wait till we debate their amendment. I am going to focus on their assertions about recent fiscal history and the role of bipartisan tax relief.

Before I address the revisionist fiscal history we heard, I would like to set the record straight on congressional history.

It was said yesterday afternoon that there were 8 years of a George W. Bush administration and Republican Congress. If the Members making these assertions would go back and check the records of the Senate, they would find that during that 8-year period Republicans controlled the Senate when it was evenly divided for a little over 5 months. For almost half the month of January 2001, Democrats held the majority because outgoing Vice President Gore broke ties. For the balance of the period from January 20, 2001, through June 6, 2001, the Senate was evenly divided, but Republicans held because of Vice President Cheney's tie breaking vote.

On June 6, 2001, the Democrats regained the majority when Senator Jeffords, previously a Republican, began caucusing with Senate Democrats. For the balance of 2001, 2002, and in early 2003, Democrats held the majority.

For two Congresses, half of President Bush's term, Republicans held a majority. For the last 2 years of the George W. Bush Presidency, Democrats controlled both Houses of Congress.

When you add it up, with the exception of a little over 4 months when the Senate was equally divided, Democrats controlled the Senate for about half the period of the George W. Bush administration.

When you hear some of our friends on the other side debate recent fiscal history, these basic facts regarding political power and accountability are obscured. Perhaps it is their opinion that Democrats were not exercising majority power during that period, but the fact is that Democrats controlled the Senate for almost half the period of the George W. bush administration.

Now let's turn to the fiscal history assertions from my friends on the other side. The revisionist history basically boils down to two conclusions:

1. That all of the bipartisan tax relief enacted during that period was skewed to the top 1 percent or top two-tenths of 1 percent of taxpayers; and

2. That all of the ''bad'' fiscal history of this decade to date is attributable to the bipartisan tax relief plans.

Not surprisingly, nearly all of the revisionists who spoke generally oppose tax relief and support tax increases. The same crew generally support spending increases and oppose spending cuts.

On the first point, two of the three speakers from the other side voted for the conference report for fiscal year 2010 budget resolution. The third speaker was not a Member of this body at that time the conference report was adopted. I am not aware, however, of his opposition to that budget which was drawn up by the Senate Democratic Caucus.

That budget was similar to President Obama's first budget. A core portion of that budget, much ballyhooed by the Democratic leadership, was an extension of the major portion of the bipartisan tax relief enacted during the period of 2001–2006. As a matter of fact, roughly 80 percent of the revenue loss from that legislation, much criticized by the three speakers yesterday afternoon, is contained in the budget that two of them voted for. Eighty percent is usually a pretty fair endorsement of any policy. Again, I have not heard the third speaker, the junior Senator from Minnesota, indicate that he doesn't support the tax relief included in the Democratic budget. Perhaps I missed something. In addition, the three speakers need to pay attention to analyses from the nonpartisan Joint Committee on Taxation.

If they did examine those analyses, they would find that, in terms of the burden of taxation, the 2001 legislation redistributed the burden from lower income taxpayers to higher income taxpayers.

Now, I turn to the second fiscal revisionist history point. That point is that all of the ''bad'' fiscal history of this decade to date is attributable to the bipartisan tax relief plans.

In the debate so far, many on this side have pointed out some key, undeniable facts. We agree with the President on one key fact. The President inherited a big deficit and a lot of debt.

The antirecessionary spending, together with lower tax receipts, and the TARP activities has set a fiscal table of a deficit of $1.2 trillion. That was on the President's desk when he took over the Oval Office on January 20, 2009. That is the highest deficit, as a percentage of the economy, in Post World War II history.

Not a pretty fiscal picture. And, as predicted several months ago, that fiscal picture got a lot uglier with the $787 billion stimulus bill. So for the folks who saw that bill as an opportunity to ''recover'' America with government taking a larger share of the economy over the long term, I say congratulations.

For those who voted for the stimulus bill, including two of the three speakers to which I refer, they put us on the path to a bigger role for the government. Over a trillion dollars of new deficit spending was hidden in that bill. The Congressional Budget Office concluded that the permanent fiscal impact of that bill totaled over $2.5 trillion over 10 years. It caused some of the extra red ink. Supporters of that bill need to own up to the fiscal course they charted.

Now, to be sure, after the other side pushed through the stimulus bill and the second half of the $700 billion of TARP money, CBO reestimated the baseline. A portion of this new red ink, upfront, is due to that reestimate.

The bottom line, however, is that reestimate occurred several weeks after the President and robust Democratic majorities took over the government. Decisions were made and the fiscal consequences followed.

Some on the other side who raises this point about the March CBO reestimate. That is fine. But, if they were to be consistent and intellectually honest, then they would have to acknowledge the CBO reestimate that occurred in 2001 after President Bush took office. The surplus went south because of economic conditions. The $5.6 trillion number so often quoted by those on the other side was illusory.

The three members should go back and take a look at what CBO said at the time. According to CBO, for the first relevant fiscal year, the tax cut represented barely 14 percent of the total change in the budget. For instance, for the same period, increased appropriations outranked the tax cut by $6 billion. So, spending above baseline, together with lower projected revenues, accounted for 86 percent of the change in the budget picture. Let me repeat that. Bipartisan tax relief was a minimal, 14-percent factor, in the change in the budget situation.

Over the long term, the tax cut was projected to account for 45 percent of the change in the budget picture. Stated another way, the 10-year surplus declined from $5.6 trillion to $1.6 trillion. Of that $4.0 trillion change, the tax cut represented about $1.7 trillion of the decline.

Let's take a look at the fiscal history before the financial meltdown hit. That conclusion is, again, in this decade, all fiscal problems are attributable to the widespread tax relief enacted in 2001, 2003, 2004, and 2006.

In 2001, President Bush came into office. He inherited an economy that was careening downhill. Investment started to go flat in 2000. The tech-fueled stock market bubble was bursting. Then came the economic shocks of the 9/11 terrorist attacks.

Add in the corporate scandals to that economic environment. And it is true, as fiscal year 2001 came to close, the projected surplus turned to a deficit. I referred to the net effects of some of these unforeseen events on the projected $5.6 trillion surplus.

Now, yesterday afternoon's three speakers may so oppose bipartisan tax relief that they want to attribute all fiscal problems to the tax relief. The official scorekeepers show the facts to be different.

Those on this side of the aisle have a different view than the revisionists. In just the right time, the 2001 tax relief plan started to kick in. The fiscal facts show as the tax relief hits its full force in 2003, the deficits grew smaller. They grew smaller in amount. They grew smaller as a percentage of the economy. This pattern continued up through 2007.

If my comments were meant to be partisan shots, I could say this favorable fiscal path from 2003 to 2007 was the only period, aside from 6 months in 2001, where Republicans controlled the White House and the Congress.

But, unlike the fiscal history revisionists, I am not trying to make any partisan points. I am just trying to get to the fiscal facts.

So, let's get the fiscal history right.

In this decade, deficits went down after the tax relief plans were put in full effect. Deficits did start to trend back up after the financial meltdown hit. I doubt the fiscal history revisionists who spoke yesterday would say that bipartisan tax relief was the cause of the financial meltdown. So, aside from that unrelated bad macroeconomic development, the trend line showed revenues on the way back up.

But that is the past. We need to make sure we understand it. But what is most important is the future. People in our States send us here to deal with future policy. This budget debate should not be about Democrats flogging Republicans and vice-versa. The people don't send us here to flog one another, like partisan cartoon cut-out characters, over past policies. They don't send us here to endlessly point fingers of blame. Now, let's focus on the fiscal consequences of the budget that is before the Senate.

President Obama rightly focused us on the future with his eloquence during the campaign. I'd like to take a quote from the President's nomination acceptance speech:

> We need a President who can face the threats of the future, not grasping at the ideas of the past.

President Obama was right.

We need a President, and I would add Congressmen and Senators, who can face the threats of the future. The legislation before us, as currently written, poses considerable threats to our fiscal future. It is too important to dodge. It is a bill that restructures one-sixth of the economy. It affects all of us and, more importantly, all of our constituents.

Grasping at ideas of the past or playing the partisan blame game will not deal with the threats to our fiscal future. Let's face the honest fiscal facts. Let's not revise fiscal history as we start this critical debate about the fiscal choices ahead of us. The people who send us here have a right to expect nothing less of us.

ORDER AUTHORIZING SIGNATURE

Mr. PRYOR. Mr. President, I ask unanimous consent that the majority

leader be authorized to sign any duly enrolled bill and joint resolution today, December 15.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. PRYOR. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

UNANIMOUS CONSENT REQUEST—H.R. 4154

Mr. PRYOR. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 4154 just received from the House and at the desk; that the Baucus substitute amendment be considered and agreed to; the bill, as amended, be read three times, passed, and the motion to reconsider be laid upon the table; that any statements relating to the measure be printed in the RECORD, without further intervening action or debate.

Mr. President, I understand the Republican leader will object, so I will withdraw this request.

The PRESIDING OFFICER. Without objection, the request is withdrawn.

MORNING BUSINESS

Mr. PRYOR. Mr. President, I ask unanimous consent 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.

BOEING DREAMLINER

Ms. CANTWELL. Mr. President, I know we are in the middle of a health care debate and I know we are focused on health care and we will be talking about that for several days, but I rise to congratulate the people of Washington State and the country on the 787 Dreamliner flight that took off from Paine Field, WA, just a few hours ago. Some people might think of that as just going to YouTube and looking at the video and seeing a plane take off and what is the significance. I tell you, there is great significance, not just for the State of Washington but for the country because this plane is a unique plane. It is a game changer as far as the market is concerned. But it is American innovation at its best. This plane, built now with 50 percent composite materials, is going to be a 20-percent more fuel-efficient plane. That is significant for our country. It is significant because it means the United States can still be a leader in manufacturing and it can still deal with something as complex as fuel efficiency in aviation.

What is prideful for us as Americans is, this is about American innovation at its best. What would Bill Boeing say about today? He would say we achieved another milestone, where we faced international competition. Yet the United States can still be a manufacturer. We can still build a product, still compete, and still win because we are innovating with aviation.

To the thousands of workers in the Boeing Company and in Puget Sound I say: Congratulations for your hard work—for the planning and implementation of taking manufacturing from aerospace with aluminum that had been the status quo for decades, to developing an entirely new plane, 50 percent with the new material.

I want the United States to continue to be a manufacturer, to still build products, to still say we can compete. So I applaud the name Dreamliner. Somebody in that company had a dream, and today it got launched when it took off from that runway. I wish to say that is the innovative spirit that has made this country great and that is the innovative spirit in which we need to invest.

HUMAN RIGHTS ENFORCEMENT ACT

Mr. DURBIN. Mr. President, I rise today to speak in support of the Human Rights Enforcement Act of 2009, which the U.S. Senate approved unanimously on November 21, 2009, and which the House of Representatives will consider today. This narrowly tailored, bipartisan legislation would make it easier for the Justice Department to hold accountable human rights abusers who seek safe haven in our country.

I would like to thank the lead Republican cosponsor of the Human Rights Enforcement Act, Senator TOM COBURN of Oklahoma. This bill is a product of the Judiciary Committee's Subcommittee on Human Rights and the Law. I am the Chairman of this Subcommittee and Senator COBURN is its ranking member. I also want to thank Judiciary Committee Chairman PAT LEAHY of Vermont and Senator BEN CARDIN of Maryland for cosponsoring this bill.

For decades, the United States has led the fight for human rights around the world. Over 60 years ago, following the Holocaust, we led the efforts to prosecute Nazi perpetrators at the Nuremberg trials. We have also supported the prosecution of human rights crimes before the International Criminal Tribunal for the former Yugoslavia, the International Criminal Tribunal for Rwanda, and the Special Court for Sierra Leone.

The world watches our efforts to hold accountable perpetrators of mass atrocities closely. When we bring human rights violators to justice, foreign governments are spurred into action, victims take heart, and future perpetrators think twice. However, when human rights violators are able to live freely in our country, America's credibility as a human rights leader is undermined.

Throughout our history, America has provided sanctuary to victims of persecution. Sadly, some refugees arrive from distant shores to begin a new life, only to encounter those who tortured them or killed their loved ones.

Two years ago, the Human Rights and the Law Subcommittee heard compelling testimony from Dr. Juan Romagoza, who endured a 22-day ordeal of torture at the hands of the National Guard in El Salvador. Dr. Romagoza received asylum in our country but later learned that two generals who were responsible for his torture had also fled to the United States. We also learned that our government was investigating over 1,000 suspected human rights violators from almost 90 countries who were in the United States.

The Human Rights and the Law Subcommittee has worked to ensure our government has the necessary authority and resources to bring perpetrators to justice and to vindicate the rights of people like Dr. Romagoza.

In the last Congress, the Subcommittee on Human Rights and the Law held hearings which identified loopholes in the law that hinder effective human rights enforcement. In order to close some of these loopholes and make it easier to prosecute human rights abuses, Senator COBURN and I introduced the Genocide Accountability Act, the Child Soldiers Accountability Act and the Trafficking in Persons Accountability Act, legislation passed unanimously by Congress and signed into law by President George W. Bush that denies safe haven in the United States to perpetrators of genocide, child soldier recruitment and use, and human trafficking.

We also examined the U.S. government agencies which bear responsibility for investigating human rights abusers and how to increase the likelihood that human rights violators will be held accountable.

There are two offices in the Justice Department's Criminal Division with jurisdiction over human rights violations. The first, the Office of Special Investigations, also known as OSI, which was established by Attorney General Richard Civiletti in 1979, has led the way in investigating, denaturalizing and removing World War II-era participants in genocide and other Nazi crimes. I want to commend OSI for its outstanding work tracking down and bringing to justice Nazi war criminals who have found safe haven in our country. Since 1979, OSI has successfully prosecuted 107 Nazis.

Just this year, OSI deported John Demjanjuk to Germany, where he is on trial for his involvement in the murder of more than 29,000 people at the Sobibor extermination camp in Nazi-

occupied Poland. Demjanjuk came to the United States in 1952 and lived in Seven Hills, OH. During World War II, Demjanjuk allegedly served as a guard at a number of concentration camps. Lanny Breuer, the Assistant Attorney General of the Criminal Division, said, ''The removal to Germany of John Demjanjuk is an historic moment in the federal government's efforts to bring Nazi war criminals to justice. Mr. Demjanjuk, a confirmed former Nazi death camp guard, denied to thousands the very freedoms he enjoyed for far too long in the United States.''

In 2004, Judiciary Committee Chairman PAT LEAHY's Anti-Atrocity Alien Deportation Act, enacted as part of the Intelligence Reform and Terrorism Prevention Act, further strengthened the Office of Special Investigations by statutorily authorizing it and expanding its jurisdiction to include serious human rights crimes committed after World War II.

The Domestic Security Section, which was established more recently, prosecutes major human rights violators and has jurisdiction over the criminal laws relating to torture, genocide, war crimes, and the use or recruitment of child soldiers. In 2008, the Domestic Security Section and the United States Attorney's Office for the Southern District of Florida obtained the first federal conviction for a human rights offense against Chuckie Taylor, son of former Liberian president Charles Taylor, for committing torture in Liberia when he served as the head of the Anti-Terrorist Unit. Taylor and other Anti-Terrorist Unit members engaged in horrific acts of torture, including shocking victims with an electric device and burning victims with molten plastic, lit cigarettes, scalding water, candle wax and an iron. Then-Attorney General Michael Mukasey said, ''Today's conviction provides a measure of justice to those who were victimized by the reprehensible acts of Charles Taylor Jr. and his associates. It sends a powerful message to human rights violators around the world that, when we can, we will hold them fully accountable for their crimes.''

The Human Rights Enforcement Act would seek to build on the important work carried out by the Office of Special Investigations and the Domestic Security Section by creating a new streamlined human rights section in the Criminal Division. My bill would combine the Office of Special Investigations, which has significant experience in investigating and denaturalizing human rights abusers, with the Domestic Security Section, which has broad jurisdiction over human rights crimes. Consolidating these two sections would allow limited law enforcement resources to be used more effectively and ensure that one section in the Justice Department has the necessary expertise and jurisdiction to prosecute or denaturalize perpetrators of serious human rights crimes.

This consolidation will also enable more effective collaboration between the Department of Justice and the Department of Homeland Security's Immigration and Customs Enforcement in identifying, prosecuting, and removing human rights violators from the United States. Immigration and Customs Enforcement has been at the forefront of the federal government's efforts to bring war criminals to justice and is currently handling over 1,000 human rights removal cases involving suspects from about 95 countries.

Immigration and Customs Enforcement and the Justice Department have complementary jurisdiction over human rights violations and partner closely in their efforts to hold accountable human rights violators. In some instances, where prosecution for a substantive human rights criminal offense is not possible, Immigration and Customs Enforcement can bring immigration charges. For example, Immigration and Customs Enforcement recently filed administrative charges against the two El Salvadoran generals who are responsible for the torture of Dr. Romagoza, which took place before the enactment of legislation prohibiting torture in the United States.

With the creation of a new streamlined human rights section in the Criminal Division of the Justice Department, Immigration and Customs Enforcement will have a stronger partner in the Justice Department to collaborate with on human rights violator law enforcement issues. This bill would require the Attorney General to consult with the Secretary of Homeland Security as appropriate, which means the Attorney General shall consult with the Secretary of Homeland Security on cases that implicate the Department of Homeland Security's jurisdiction and competencies.

The consolidation of the two sections in the Criminal Division of the Justice Department with jurisdiction over human rights violations would not affect or change Immigration and Customs Enforcement's existing jurisdiction over human rights violators. Immigration and Customs Enforcement will continue to have primary authority for removing human rights violators from the United States through the immigration courts.

At a hearing of the Human Rights and the Law Subcommittee on October 6, 2009, the Justice Department and Immigration and Customs Enforcement expressed strong support for combining the Office of Special Investigations and the Domestic Security Section. However, since the Office of Special Investigations is statutorily authorized, the Justice Department needs Congressional authorization to move forward on merging these two sections.

The Human Rights Enforcement Act also includes a number of technical and conforming amendments, including: 1) technical changes to the criminal law on genocide (18 U.S.C. 1091) that the Justice Department requested in 2007 to make it easier to prosecute perpetrators of genocide; 2) clarifying that the immigration provisions of the Child Soldiers Accountability Act apply to offenses committed before the bill's enactment; 3) a conforming amendment to the Immigration and Nationality Act required by the enactment of the Genocide Accountability Act; and 4) a conforming amendment to the material support statute, made necessary by the enactment of the Genocide Accountability Act and the Child Soldiers Accountability Act, making it illegal to provide material support to genocide and the use or recruitment of child soldiers. These technical changes will facilitate the government's ability to prosecute perpetrators who commit genocide or use child soldiers.

Dr. Juan Romagoza survived horrible human rights abuses, and had the courage to flee his home and find sanctuary in the United States, where he became an American and made great contributions to our country. We owe it to Dr. Romagoza, and countless others like him, to ensure that America does not provide safe haven to those who violate fundamental human rights. From John Demjanjuk, who helped massacre over 29,000 Jews during World War II, to the Salvadoran generals responsible for torturing Dr. Juan Romagoza, we have a responsibility to bring human rights violators to justice.

I thank my colleagues for supporting this legislation and hope it will be enacted into law soon.

PENDING NOMINATIONS

Mr. LEAHY. Mr. President, two weeks ago, I challenged Senate Republicans to do as well as Senate Democrats did in December 2001 when we proceeded to confirm 10 of President Bush's nominees as Federal judges. Regrettably, my plea has been ignored. Senate Republicans are failing the challenge. The Senate has been allowed to confirm only one judicial nominee all month. On December 1, after almost 6 weeks of unexplained delays, the Senate was allowed to consider the nomination of Judge Jacqueline Nguyen to fill a vacancy on the Federal Court for the Central District of California. When finally considered, she was confirmed unanimously by a vote of 97 to 0. Since then, not a single judicial nominee has been considered. It is now 2 weeks later, December 15.

Judicial nominees have been and are available for consideration. This lack of action is no fault of the President. He has made quality nominations. They have had hearings and have been considered by the Senate Judiciary Committee and favorably reported to the Senate. Indeed, the logjam has only grown over the last 2 weeks. Five additional judicial nominations have been added to the Senate calendar since December 1, bringing the total number of judicial nominations ready for Senate action, yet delayed by Republican obstruction, to 12. One has been ready for

Senate consideration for more than 13 weeks, another more than 10 weeks, and the list goes on. The majority leader and Democratic Senators have been ready to proceed. The Republican Senate leadership has not.

There are now more judicial nominees awaiting confirmation on the Senate's Executive Calendar than have been confirmed since the beginning of the Obama administration. Due to delays and obstruction by the Republican minority, we have only been able to consider 10 judicial nominations to the Federal circuit and district courts all year, and for one of them, although supported by the longest serving Republican in the Senate, we had to overcome a full-fledged filibuster led by the Republican leadership. As a result, we will not only fall well short of the total of 28 judicial confirmations the Democratic Senate majority worked to confirm in President Bush's first year in office, but we threaten to achieve the lowest number of judicial confirmations in the first year of a new Presidency in modern history.

It is clear that the Republican leadership has returned 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 even to public criticism of their actions by Chief Justice Rehnquist during those years. Their delays this year may leave us well short even of their low point during President Clinton's first term, when the Republican Senate majority would only allow 17 judicial confirmations during the entire 1996 session. That was a Presidential election year and the end of President Clinton's first term. By contrast, this is just the first year of the Obama administration.

We need to act on the judicial nominees on the Senate Executive Calendar without further delay. 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.

The 12 judicial nominations that have been given hearings and favorable consideration by the Senate Judiciary Committee and that remain stalled before the Senate are Beverly Martin of Georgia, nominated to the Eleventh Circuit; Joseph Greenaway of New Jersey, nominated to the Third Circuit; Edward Chen, nominated to the District Court for the Northern District of California; Dolly Gee, nominated to the District Court for the Central District of California; Richard Seeborg, nominated to the District Court for the Northern District of California, Barbara Keenan of Virginia, nominated to the Fourth Circuit; Jane Stranch of Tennessee, nominated to the Sixth Circuit; Thomas Vanaskie of Pennsylvania, nominated to the Third Circuit; Louis Butler, nominated to the District Court for the Western District of Wisconsin; Denny Chin of New York, nominated to the Second Circuit; Rosanna Malouf Peterson, nominated to the District Court for the Eastern District of Washington; and William Conley, nominated to the District Court for the Western District of Wisconsin.

Acting on these nominations, we can confirm 13 nominees this month. In December 2001, a Democratic Senate majority proceeded to confirm 10 of President Bush's nominees and ended that year having confirmed 28 new judges nominated by a President of the other party. We achieved those results with a controversial and confrontational Republican President after a midyear change to a Democratic majority in the Senate. We did so in spite of the attacks of September 11; despite the anthrax-laced letters sent to the Senate that closed our offices; and while working virtually around the clock on the PATRIOT Act for 6 weeks.

At the end of the Senate's 2001 session, only four judicial nominations were left on the Senate Executive Calendar, all of which were confirmed soon after the Senate returned in 2002. At the end of the first session of Congress during President Clinton's first term, just one judicial nominee was left on the Senate Executive Calendar. At the end of the President George H.W. Bush's first year in office, a Democratic Senate majority left just two judicial nominations pending on the Senate Executive Calendar. At the end of the first year of President Reagan's first term—a year in which the Senate confirmed 41 of his Federal circuit and district court nominees—not a single judicial nomination was left on the Senate Executive Calendar.

In stark contrast, there are now 12 judicial nominees on the Senate Executive Calendar and no agreement from Senate Republicans to consider a single one. That is a significant change from our history and tradition of confirming judicial nominations that have been reported favorably by the Senate Judiciary Committee by the end of a session.

The record of obstruction of the Senate Republicans is just as disappointing when we consider the executive nominations that have been reported by the Judiciary Committee. There are currently 15 executive nominations that have been reported favorably by the Senate Judiciary Committee pending on the Senate Executive Calendar, including nominations for Assistant Attorneys General to run three of the 11 divisions at the Department of Justice. Each of these nominations has been pending 4 months or longer.

The President nominated Dawn Johnsen to lead the Office of Legal Counsel on February 11. Her nomination has been pending on the Senate Executive Calendar since March 19. That is the longest pending nomination on the calendar by over 2 months. We did not treat President Bush's first nominee to head the Office of Legal Counsel the same way. We confirmed Jay Bybee to that post only 49 days after he was nominated by President Bush, and only 5 days after his nomination was reported by the Senate Judiciary Committee.

Mary Smith's nomination to be the Assistant Attorney General in charge of the Tax Division has been pending on the Senate's Executive Calendar since June 11—more than 6 months. We confirmed President Bush's first nomination to that position, Eileen O'Connor, only 57 days after her nomination was made and 1 day after her nomination was reported by the Senate Judiciary Committee. Her replacement, Nathan Hochman, was confirmed without delay, just 34 days after his nomination.

Among the nominations still waiting for consideration is that of Christopher Schroeder, nominated on June 4 to be Assistant Attorney General for the Office of Legal Policy, OLP. Mr. Schroeder's nomination has been pending before the Senate since July of this year when he was reported by the Senate Judiciary Committee by voice vote and without dissent. There was no objection from the Republican members of the committee on his nomination, so it puzzles me why we cannot move to a vote.

President Bush appointed four Assistant Attorneys General for the Office of Legal Policy. Each was confirmed expeditiously by the Senate. In fact, his first nominee to that post, Viet Dinh, was confirmed by a vote of 96 to 1 just 1 month after he was nominated and only a week after his nomination was reported by the Senate Judiciary Committee. Professor Schroeder's nomination has been pending for over 4 months. President Bush's three subsequent nominees to head OLP—Daniel Bryant, Rachel Brand, and Elisebeth Cook—were each confirmed by voice vote in a shorter time than Professor Schroeder's nomination has been pending.

Senate Republicans should not further delay consideration of these important nominations.

Returning to judicial nominations, I hope that instead of withholding consent and threatening filibusters of President Obama's nominees, Senate Republicans will treat President Obama's nominees fairly. I made sure that we treated President Bush's nominees more fairly than President Clinton's nominees had been treated. I want to continue that progress, but we 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.

President Obama has reached out and consulted with home State Senators

from both sides of the aisle regarding his judicial nominees. Instead of praising the President for consulting with Republican Senators, the Senate Republican leadership has doubled back on what they demanded when a Republican was in the White House. No more do they talk about each nominee being entitled to an up-or-down vote. That position is abandoned and forgotten. Instead, they now seek to filibuster and delay judicial nominations. When President Bush worked with Senators across the aisle, I praised him and expedited consideration of his nominees. When President Obama reaches across the aisle, the Senate Republican leadership delays and obstructs his qualified nominees.

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. As I have noted, there are 12 more qualified judicial nominations awaiting Senate action on the Senate Executive Calendar. Another nomination should be considered by the Judiciary Committee this week. I hope that with the session drawing to a close Judge Rogeriee Thompson of Rhode Island will not be needlessly delayed. 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 had reduced judicial vacancies to as low as 34, even though it was a Presidential election year. As matters stand today, judicial vacancies have spiked, and we will start 2010 with the highest number of vacancies on article III courts since 1994, when the vacancies created by the last comprehensive judgeship bill were still being filled. While it has been nearly 20 years since we enacted a Federal judgeship bill, judicial vacancies are nearing record levels, with 97 current vacancies and another 23 already announced. If we had proceeded on the judgeship bill recommended by the U.S. Courts to address the growing burden on our Federal judiciary and provide access to justice for all Americans, vacancies would stand at 160, by far the highest on record. 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.

There is still time to act on these nominations before the Senate recesses this year. I hope Senate Republicans will lift their objections and allow us to proceed on the 27 nominations reported by the Judiciary Committee. Absent cooperation to confirm nominations, this Congress will be recorded in history as one of the least productive in the confirmation of judicial nominations. I hope the New Year will bring a renewed spirit of cooperation.

RECEIPT OF ASYLUM

Mr. LEAHY. Mr. President, I am pleased to learn that, after 14 years of legal struggle, Ms. Rody Alvarado has finally received asylum in the United States. The details of Ms. Alvarado's case are shocking. She suffered from horrific domestic violence in her home country of Guatemala and sought protection in the United States under our asylum laws. Because persecution of this type had not previously been recognized as a basis for refugee or asylum protection, Ms. Alvarado was forced to fight a long legal battle to win her case.

The administrations of three different Presidents—Clinton, Bush and Obama—have grappled with how to handle gender-based asylum claims, but the resolution of this case brings us closer to the end of this journey. Ms. Alvarado can finally feel safe here in the United States because she is no longer at risk of being deported to Guatemala. The Obama administration must now issue regulations to ensure that other victims of domestic violence whose abuse rises to the level of persecution can obtain the same protection as refugees or asylees.

Ms. Alvarado fled Guatemala in 1995 after being beaten daily and raped repeatedly by her husband. When she became pregnant but refused to terminate her pregnancy, her husband kicked her repeatedly in the lower spine. Ms. Alvarado had previously tried to escape the abuse, seeking protection in another part of Guatemala, but her husband tracked her down and threatened to kill her if she left their home again. We know that Ms. Alvarado notified Guatemalan police at least five separate times, but the police refused to respond, telling her that her desperate situation was a domestic dispute that needed to be settled at home.

Over the past 14 years, Ms. Alvarado's case has been considered by immigration judges, the Board of Immigration Appeals, BIA, five different Attorneys General, and three Secretaries of Homeland Security. Throughout this extensive consideration, the core facts of her case have never been disputed. All parties have agreed that Ms. Alvarado suffered extreme abuse at the hands of her husband and that the Guatemalan Government would not protect her. All parties agreed that she has a well-founded fear that she would be abused again if she was forced to return to Guatemala.

The dispute in Ms. Alvarado's case centered on whether the abuse she suffered was persecution under the terms of the Refugee Convention and applicable U.S. law. To obtain protection in the United States, an asylum seeker must demonstrate that they have a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group.

I first wrote to Attorney General Janet Reno in December 1999, when the BIA reversed Ms. Alvarado's grant of asylum, concluding that her abuse was not persecution on account of membership in a particular social group. This decision was particularly troubling because it left unclear what grounds, if any, could be applied to a victim of severe domestic abuse who cannot obtain the protection of her country of origin. I wrote to Attorney General Reno again in February and September 2000 asking her to exercise her authority to review the case, called Matter of R-A-, and to reverse the BIA's decision. Unfortunately, the case was not reversed at that time, and it then languished for years. I wrote to Attorney General Ashcroft in June 2004 asking him to work with the Department of Homeland Security, DHS, to issue regulations to govern cases such as Ms. Alvarado's and to then decide her case in accordance with such rules. When he was a nominee to be Attorney General in January 2005, I asked Mr. Alberto Gonzales to commit to taking up the case and resolving it if he was confirmed. Mr. Gonzales promised to work with DHS to finalize regulations but did not take any action during his years as Attorney General.

Ten years after I and other Members of Congress first sought appropriate action and the fair resolution of this case, we celebrate the long-overdue outcome. While I am dismayed at the length of time Ms. Alvarado has lived with fear and uncertainty, the final resolution of this case gives me hope that abuse victims like Ms. Alvarado who meet the other conditions of asylum will be able to find safety in the United States.

The Obama administration has laid out a welcomed, new policy in its legal briefs in this case, and I thank the President, Secretary Napolitano, and Attorney General Holder for bringing this case to such a positive resolution. Yet the administration's work is not done. It must issue binding regulations so that asylum seekers whose cases have been held in limbo for years can also be resolved and that future cases are not delayed in adjudication. I urge the administration to immediately initiate a process of notice and comment rulemaking so that asylum seekers, practitioners, and other experts can contribute to the formulation of new rules.

Today, I commend Ms. Alvarado on the courage she has demonstrated over many years while seeking protection in the United States. I congratulate her and wish her all the best as she finally experiences true freedom from persecution and the full scope of liberties enjoyed by Americans.

A TRIBUTE TO ROBERT B. HEMLEY

Mr. LEAHY. Mr. President, last week, the Senate Judiciary Committee approved the media shield bill in a bipartisan vote of 14 to 5. This legislation would establish a qualified privilege for journalists to protect their confidential sources and the public's right to

know. At a time when the Senate is working to recognize the importance of protecting Americans' first amendment rights, I am proud to recognize a Burlington lawyer who was recently recognized by the Vermont Press Association for his lifetime commitment to the first amendment and the public's right to know.

On December 3, 2009, Robert B. Hemley was awarded the Matthew Lyon Award during the Association's annual awards banquet in Montpelier, Vermont. As a fellow Matthew Lyon Award recipient, I share with Robert a passion about the need for each generation to defend the first amendment rights that are so crucial to all Vermonters and to every American. Robert has worked to bring greater transparency and accountability to our government by representing journalists and newspapers in instances in which they were improperly forced to testify in violation of the first amendment, and by helping to create the Vermont Coalition for Open Government.

In each era there will always be much to do to bring greater openness and accountability to government of, by, and for the people. I am pleased to know Robert Hemley will continue to bring his expertise and dedication to this fight.

I ask unanimous consent to have printed in the RECORD an article from the St. Albans Messenger.

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

[From the St. Albans Messenger, Dec. 1, 2009]

BURLINGTON LAWYER WINS RECOGNITION FOR COMMITMENT TO FIRST AMENDMENT

MONTPELIER.—Burlington lawyer Robert B. Hemley has been selected to receive the Matthew Lyon Award for his lifetime commitment to the First Amendment and public's right to know the truth in Vermont.

The Vermont Press Association is scheduled to present the award to Hemley during its annual awards banquet at noon Thursday (Dec. 3) at the Capitol Plaza in Montpelier.

VPA President Bethany Dunbar, editor of the Chronicle in Barton, said Hemley has been a First Amendment leader in the fight against sealed public records, closed courtrooms and improper attempts to force reporters to testify in violation of the First Amendment. Hemley also has successfully defended the media against defamation and invasion-of-privacy lawsuits and other false claims.

The VPA created the award to honor people who have an unwavering devotion to the five freedoms within the First Amendment and to the belief that the public's right to know the truth is essential in a self-governed democracy.

The First Amendment award is named for the former Vermont congressman, who was jailed in 1798 under the Alien and Sedition Act for sending a letter to the editor criticizing President John Adams.

While Lyon was serving his federal sentence in a Vergennes jail, Vermonters reelected him to the U.S. House of Representatives. Hemley, who is a shareholder in the Gravel and Shea law firm, has been recruited to the write the Vermont section of the national guides on libel, privacy, and access for both the media Libel Resource Center and the Reporters' Committee for Freedom of the Press for more than 20 years.

He has shared his expertise and participated in various training sessions for judges, lawyers, the media and the public. He helped create the Vermont Coalition for Open Government and has been invited through the years by the Vermont Legislature to offer testimony on several First Amendment issues.

Hemley has represented: St. Albans Messenger, Burlington Free Press, Rutland Herald, Times Argus, Valley news, Bennington Banner, the Associated Press, United Press International, USA Today, New York Times, New York Daily News, along with WCAX–TV, Vermont Public Radio and several weekly newspapers, including in Randolph, Stowe, Waitsfield and Burlington.

Before arriving in Vermont in 1976, Hemley was an assistant U.S. Attorney for the Southern District of New York and also worked for a Wall Street law firm. He earned degrees from Amherst College and New York University Law School and is listed in the Best Lawyers in America. Hemley has chaired the District Court Advisory Committee for Vermont since 1993.

He lives in Burlington with his wife, Marcia, and they have three children: Amanda, an assistant state's attorney for Dade County, Fla.; Mark, who lives in Boston, and Ian, who attends school in Atlanta.

Previous Matthew Lyon winners include Patrick J. Leahy for his work as a state prosecutor and as a U.S. senator; and Edward J. Cashman for his efforts as Chittenden Superior Court clerk, a state prosecutor and state judge.

IRAN

Mr. LEVIN. Mr. President, I want to take a few moments today to comment on recent events in Iran, the continuing protests against that nation's ruling regime, the brutal response of that regime to the legitimate protests of Iran's people, and one small step the United States can and should take to aid the people of Iran in exercising the basic human right to protest and hold their own government accountable.

As my colleagues know well, student protests in Tehran and other cities took place on Dec. 7, Student Day, the anniversary of the 1953 attacks by the shah's security services that left three student protesters dead. Just as those students sought to protest against an unjust and repressive government, so did today's students. And again, Iran's government responded with intimidation, violence and repression.

Iranian security forces, and paramilitary militias allied with government hard-liners, used teargas, batons and beatings to attack nonviolent protesters on the campus of Tehran University and at other universities. The government's chief prosecutor told the state-controlled news agency—apparently without irony—''So far we have shown restraint,'' and threatened even harsher methods to end the protests.

Sadly, this is a recurring theme in Iran. Outraged by overwhelming evidence of fraud designed to keep President Ahmadinejad in power last June, students and other Iranians took to the streets. These nonviolent protests were met by the regime with escalating levels of brutality. According to a recent report from the human rights group Amnesty International, government-sponsored violence and repression in Iran since the election has reached the highest level in 20 years. Hundreds of people have been rounded up and imprisoned, often under appalling conditions, without access to legal representation or indeed any contact with the outside world. Iranian citizens, according to the report, were charged with vague offenses unconnected to any recognizable criminal charge under Iranian law.

More than 100 were paraded before cameras in show trials, with visible signs of abuse. The Amnesty International report includes evidence that the pace of executions by the Iranian government has increased, a clear and chilling message to the regime's critics. And citizens released from detention made credible and horrific charges of abuse while in custody, including allegations of the widespread use of rape.

This deplorable record is why I and six colleagues introduced a resolution last month, approved by this body, expressing the sense of the Senate that the government of Iran has routinely violated the human rights of its citizens, and calling on the Iranian government to fulfill its obligations under international law and its own constitution to honor and protect the fundamental rights to which its citizens, and all human beings, are entitled. We recognized the need for a strong statement of condemnation of the regime's behavior, and of solidarity with those Iranians seeking to exercise their right to protest. The Iranian government must know that the world is watching.

Mr. President, there is more the United States can do. I draw my colleagues' attention to a notice from the State Department that the administration will waive certain provisions of the Iran-Iraq Arms Nonproliferation Act of 1992 with respect to the export of personal, Internet-based communications tools to Iran. This is an important response to the Iranian government's crackdown on its people. The regime has sharply curtailed the actions of foreign media representatives in Iran, making independent observations of the situation there difficult or impossible to report. Much of what we know about the regime's repression has come from first-hand accounts by Iranian citizens, distributed via Internet tools such as YouTube and Twitter. These media outlets have become vital, not only to those of us outside Iran seeking information about events within the country, but to Iranian citizens seeking to communicate with one another. And they are especially important given the near total absence of independent news media in Iran. The regime has undertaken, even before the June election, a systematic effort to eliminate newspapers or broadcasters that report critically on the government's activities. And Iran's Revolutionary Guards, closely connected to government hardliners, have sought to add media and communication companies to its growing commercial empire,

tightening the regime's grip on communications within Iran.

The State Department recently notified Congress that it intends to waive provisions of our sanctions against Iran to allow Iranians to download free, mass-market software used in activities such as e-mail, instant messaging and social networking. According to the State Department, ''U.S. sanctions on Iran are having an unintended chilling effect on the ability of companies such as Microsoft and Google to continue providing essential communications tools to ordinary Iranians. This waiver will authorize free downloads to Iran of certain nominally dual-use software (because of low-level encryption elements) classified as mass market software by the Department of Commerce and essential for the exchange of personal communications and/or sharing of information over the internet.''

Granting of this waiver is an important step in ensuring that our actions here do not impede the attempts by Iranians to exercise their human rights. I applaud the administration for its decision, and hope the people of Iran will view this as one more sign of the solidarity between them and the people of the United States. I ask that a letter to me from Richard R. Verma, assistant secretary of state for legislative affairs, informing the Senate Armed Services Committee of this waiver decision, be printed in the RECORD.

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

U.S. DEPARTMENT OF STATE,
Washington, DC, December 15, 2009.

Hon. CARL LEVIN,
Chairman, Committee on Armed Services, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The enclosed report is being provided consistent with Section 1606 of the Iran-Iraq Arms Non-Proliferation Act of 1992 (P.L. 102–484) (the ''Act''). The Under Secretary of State has determined that the issuance of a license for a proposed export to Iran is ''essential to the national interest of the United States.'' The attached report provides a specific and detailed rationale for this determination. The waiver authority under Section 1606 of the Act will not be exercised until at least 15 days after this report is transmitted to the Congress.

The Department of State is recommending that the Department of Treasury's Office of Foreign Assets Control (OFAC) issue a general license that would authorize downloads of free mass market software by companies such as Microsoft and Google to Iran necessary for the exchange of personal communications and/or sharing of information over the Internet such as instant messaging, chat and email, and social networking. This software is necessary to foster and support the free flow of information to individual Iranian citizens and is therefore essential to the national interest of the United States.

Please do not hesitate to contact us if we can be of further assistance.

Sincerely,

RICHARD R. VERMA,
Assistant Secretary, Legislative Affairs.

REPORT UNDER THE IRAN-IRAQ ARMS NON-PROLIFERATION ACT OF 1992

This report is being provided consistent with Section 1606 of the Iran-Iraq Arms Non-Proliferation Act of 1992 (P.L. 102–484) (the ''Act''). Section 1603 of the Act applies with respect to Iran certain sanctions specified in paragraphs (1) through (4) of Section 586G(a) of the Iraq Sanctions Act of 1990 (P.L. 101–513) (the ''ISA''). This includes the requirement under Section 586G(a)(3) of the ISA to use the authorities of Section 6 of the Export Administration Act of 1979 (''EAA'') to prohibit the export to Iran of any goods or technology listed pursuant to Section 6 of the EAA or Section 5(c)(1) of the EAA on the control list provided for in Section 4(b) of the EAA, unless such export is pursuant to a contract in effect before the effective date of the Act (October 23, 1992).

Pursuant to Section 1606 of the Act, the President may waive the requirement to impose a sanction described in Section 1603 of the Act by determining that it is essential to the national interest of the United States to exercise such waiver authority. On September 27, 1994, the President delegated his authorities under the Act to the Secretary of State. Subsequently, on January 12, 2007, the Secretary of State delegated these authorities to the Under Secretary for Arms Control and International Security (DA 293–1).

Personal Internet-based communications are a vital tool for change in Iran as recent events have demonstrated. However, U.S. sanctions on Iran are having an unintended chilling effect on the ability of companies such as Microsoft and Google to continue providing essential communications tools to ordinary Iranians. This waiver will authorize free downloads to Iran of certain nominally dual-use software (because of low-level encryption elements) classified as mass market software by the Department of Commerce and essential for the exchange of personal communications and/or sharing of information over the Internet. The waiver will enable Treasury's Office of Foreign Assets Control to issue a broader general license covering these downloads and related services. This general license will be comparable to exemptions which already exist for the exchange of direct mail and phone calls. The new general license will specifically exclude from its authorization the direct or indirect exportation of services or software with knowledge or reason to know that such services or software are intended for the Government of Iran.

The Under Secretary has determined that it is essential to the national interest of the United States to exercise the authority of Section 1606 of the Act not to impose the sanction described in Section 1603 of the Act and Section 586(a)(3) of the ISA and to permit the issuance of a general license for this kind of software.

SLOVAKIA AND HUNGARY RELATIONS

Mr. CARDIN. Mr. President, in 1991, then-Czechoslovak President Vaclav Havel brought together his counterparts from Poland and Hungary. Taking inspiration from a 14th century meeting of Central European kings, these 20th century leaders returned to the same Danube town of Visegrad with a view to eliminating the remnants of the communist bloc in Central Europe; overcoming historic animosities between Central European countries; and promoting European integration.

Today, the Czech Republic, Hungary, Poland and Slovakia are together known as the Visegrad Group, and all four have successfully joined NATO and the European Union. They are anchors in the Trans-Atlantic alliance, and I am pleased to have had the opportunity to travel to all four of these countries where I have met with public officials, non-governmental representatives and ethnic and religious community leaders.

Unfortunately, it appears that some additional work is necessary to address one of the principal goals of the Visegrad Group; namely, overcoming historic animosities. In recent months, relations between Hungary and Slovakia have been strained. Having traveled in the region and having met with leaders from both countries during their recent visits to Washington, I would like to share a few observations.

First, an amendment to the Slovak language law, which was adopted in June and will enter into force in January, has caused a great deal of concern that the use of the Hungarian language by the Hungarian minority in Slovakia will be unduly or unfairly restricted. Unfortunately, that anxiety has been whipped up, in part, by a number of inaccurate and exaggerated statements about the law.

The amendment to the state language law only governs the use of the state language by official public bodies. These state entities may be fined if they fail to ensure that Slovak—the state language—is used in addition to the minority languages permitted by law. The amendment does not allow fines to be imposed on individuals, and certainly not for speaking Hungarian or any other minority language in private, contrary to what is sometimes implied.

The OSCE High Commissioner on National Minorities has been meeting with officials from both countries and summarized the Slovak law in his most recent report to the OSCE Permanent Council:

> The adopted amendments to the State Language Law pursue a legitimate aim, namely, to strengthen the position of the State language, and, overall, are in line with international standards. Some parts of the law, however, are ambiguous and may be misinterpreted, leading to a negative impact on the rights of persons belonging to national minorities.

Since the law has not yet come into effect, there is particular concern that even if the law itself is consistent with international norms, the implementation of the law may not be.

I am heartened that Slovakia and Hungary have continued to engage with one of the OSCE's most respected institutions—the High Commissioner on National Minorities—on this sensitive issue, and I am confident that their continued discussions will be constructive.

At the same time, I would flag a number of factors or developments that have created the impression that the Slovak Government has some hostility toward the Hungarian minority.

Those factors include but are not limited to the participation of the extremist Slovak National Party, SNS,

in the government itself; the SNS control of the Ministry of Education, one of the most sensitive ministries for ethnic minorities; the Ministry of Education's previous position that it would require Slovak-language place names in Hungarian language textbooks; the handling of the investigation into the 2006 Hedvig Malinova case in a manner that makes it impossible to have confidence in the results of the investigation, and subsequent threats to charge Ms. Malinova with perjury; and the adoption of a resolution by the parliament honoring Andrei Hlinka, notwithstanding his notorious and noxious anti-Hungarian, anti-Semitic, and anti-Roma positions.

All that said, developments in Hungary have done little to calm the waters. Hungary itself has been gripped by a frightening rise in extremism, manifested by statements and actions of the Hungarian Guard, the ''64 Counties'' movement, and the extremist party Jobbik, all of which are known for their irredentist, anti-Semitic, and anti-Roma postures. Murders and other violent attacks against Roma, repeated attacks by vandals on the Slovak Institute in Budapest, attacks on property in Budapest's Jewish quarter in September, and demonstrations which have blocked the border with Slovakia and where the Slovak flag is burned illustrate the extent to which the Hungarian social fabric is being tested.

Not coincidentally, both Hungary and Slovakia have parliamentary elections next year, in April and June respectively, and, under those circumstances, it may suit extremist elements in both countries just fine to have these sorts of developments: nationalists in Slovakia can pretend to be protecting Slovakia's language and culture—indeed, the very state—from the dangerous overreach of Hungarians. Hungarian nationalists—on both sides of the border—can pretend that Hungarian minorities require their singular protection—best achieved by remembering them come election day. Meanwhile, the vast majority of good-natured Slovaks and Hungarians, who have gotten along rather well for most of the last decade, may find their better natures overshadowed by the words and deeds of a vocal few.

In meetings with Slovak and Hungarian officials alike, I have urged my colleagues to be particularly mindful of the need for restraint in this pre-election season, and I have welcomed the efforts of those individuals who have chosen thoughtful engagement over mindless provocation. I hope both countries will continue their engagement with the OSCE High Commissioner on National Minorities, whom I believe can play a constructive role in addressing minority and other bilateral concerns.

ADDITIONAL STATEMENTS

REMEMBERING PIERRE PELHAM

• Mr. SHELBY. Mr. President, I pay tribute to Pierre Pelham, a former colleague of mine in the Alabama State Senate, who recently passed away. He was a personal friend and, along with his family, I mourn his passing.

A native of Chatom, AL, and a resident of Mobile, AL, Pierre was born on July 20, 1929, to Judge and Mrs. Joe M. Pelham, Jr. An incredibly bright student, he graduated Phi Beta Kappa from the University of Alabama and received his J.D. cum laude from Harvard Law School. During the Korean war, Pierre served as a captain in the Army and received both the Combat Infantryman Badge and Expert Infantryman Badge.

After his service in the Army, Pierre returned to Alabama and began to practice law. Described by many as brilliant, Pierre often took on cases that other lawyers did not want. One of his more interesting cases involved representing Aristotle Onassis' wife in her divorce from the wealthy shipping magnate.

In the 1960s, Pierre began to pursue his interest in politics. He served as the national campaign coordinator for Governor George Wallace and later as a delegate to the Democratic National Convention from Alabama's 1st Congressional District in 1960 and 1964. In 1966, Pierre was elected to serve in the Alabama State Senate. It was there that I had the distinct pleasure of working with him.

In 1970, Pierre was elected to serve as president pro tempore of the Senate. Pierre was renowned by our colleagues as an excellent orator and an exceptionally persuasive State senator. When word would spread around the State capitol that Pierre was speaking on the senate floor, it was not uncommon for the gallery to fill with spectators and for members of the House to cross over to the Senate to watch what would surely be an extraordinary speech. His articulation and command of the English language were simply captivating.

Although Pierre eventually retired from public life, as a fellow of Harvard's Kennedy Institute of Politics, he remained interested in national, State, and local affairs his entire life. Most people in Mobile will remember Pierre for his many contributions as a State senator to South Alabama, most notably his support for the creation of the University of South Alabama College of Medicine. I knew him to be honest, hardworking, and a committed State senator. He remained dedicated to his family and the people of Alabama throughout his life.

Pierre is loved and respected and will be missed by his wife Eva Pelham; his sons Marc Pelham and Joseph Pelham, IV; his daughters Pierrette Prestridge and Patrice Pelham; and 12 grandchildren. I ask the entire Senate to join me in recognizing and honoring the life of my friend, Pierre Pelham.•

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Pate, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting nominations which were referred to the Committee on Armed Services.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

ENROLLED BILL SIGNED

The President pro tempore (Mr. BYRD) reported that he had signed the following enrolled bill, which was previously signed by the Speaker of the House:

H.R. 3288. An act making appropriations for the Departments of Transportation, and Housing and Urban Development, and related agencies for the fiscal year ending September 30, 2010, and for other purposes.

At 3:39 p.m., a message from the House of Representatives delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, with an amendment, in which it requests the concurrence of the Senate:

S. 303. A bill to reauthorize and improve the Federal Financial Assistance Management Improvement Act of 1999.

ENROLLED JOINT RESOLUTION SIGNED

At 6:13 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled joint resolution:

H.J. Res. 62. Joint resolution appointing the day for the convening of the second session of the One Hundred Eleventh Congress.

The enrolled joint resolution was subsequently signed by the Acting President pro tempore (Mr. REID).

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–4014. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of the Atlantic Low Offshore Airspace Area; East Coast United States'' ((RIN2120–AA66)(Docket No. FAA–2008–1170)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4015. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule

entitled ''Amendment of the South Florida Low Offshore Airspace Area; Florida'' ((RIN2120–AA66)(Docket No. FAA–2008–1167)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4016. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class D and E Airspace; Fort Stewart (Hinesville), GA'' ((RIN2120–AA66)(Docket No. FAA–2009–0959)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4017. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Jackson, AL'' ((RIN2120–AA66)(Docket No. FAA–2009–0937)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4018. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Mountain City, TN'' ((RIN2120–AA66)(Docket No. FAA–2009–0061)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4019. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Fort A.P. Hill, VA'' ((RIN2120–AA66)(Docket No. FAA–2009–0739)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4020. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revocation of Class E Airspace; Hinesville, GA'' ((RIN2120–AA66)(Docket No. FAA–2009–0960)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4021. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model DHC–8–400 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0784)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4022. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Sikorsky Aircraft Corporation (Sikorsky) Model S–92A Helicopters'' ((RIN2120–AA64)(Docket No. FAA–2009–1130)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4023. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A300 B2–1C, A300 B2–203, A300 B2K–3C, A300 B4–103, A300 B4–203, and A300 B4–2C Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0055)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4024. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model DHC–8–400, DHC–8–401, and DHC–8–402 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1106)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4025. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Honeywell International Inc. LTS101 Series Turboshaft and LTP101 Series Turboprop Engines'' ((RIN2120–AA64)(Docket No. FAA–2008–1019)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4026. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Saab AB, Saab Aerosystem Model SAAB 2000 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0654)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4027. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; DG Flugzeugbau GmbH Models DG–500 MB, DG–808C and DG–800B Gliders'' ((RIN2120–AA64)(Docket No. FAA–2009–1103)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4028. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; General Electric Company (GE) CF34–1A, CF34–3A, and CF34–3B Series Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0328)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4029. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; SOCATA Model TBM 700 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0886)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4030. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Cessna Aircraft Company Model 525A Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1096)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4031. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB–500 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0870)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4032. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Thielert Aircraft Engines GmbH (TAE) Model TAE 125–01 Reciprocating Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0753)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4033. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Vulcanair S.p.A. Models P 68, P 68B, P 68C, P 68C–TC, and P 68 ''OBSERVER'' Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0869)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4034. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; AVOX Systems and B/E Aerospace Oxygen Cylinder Assemblies, as Installed on Various Transport Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0915)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4035. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Inc. Model CL–600–2C10 (Regional Jet Series 700, 701 and 702), CL–600–2D15 (Regional Jet Series 705), and CL–600–2D24 (Regional Jet Series 900) Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1075)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4036. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Pratt and Whitney JT8D–7, –7A, –7B, –9, –9A, –11, –15, and –17 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0317)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4037. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Scheibe–Flugzeugbau GmbH Models Bergfalke–III, Bergfalke–II/55, SF 25C, and SF–26A Standard Gliders'' ((RIN2120–AA64)(Docket No. FAA–2009–0800)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4038. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A318–111 and –112 Series Airplanes, and Model A319, A320, and A321 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1073)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4039. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls–Royce plc RB211–Trent 800 Series Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0674)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4040. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing 737–600, –700, –700C, and –800 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0411)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4041. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; General Electric Company CF6–50C Series Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2006–24171)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4042. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 777–200, –200LR, –300, and –300ER Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0571)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4043. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Hawker Beechcraft Corporation Models 58, 58A, 58P, 58PA, 58TC, 58TCA, 95–B55, 95–B55A, A36, A36TC, B36TC, E55, E55A, F33A, and V35B Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0797)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4044. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; McDonnell Douglas Model DC–9–14, DC–9–15, and DC–9–15F, Airplanes; and McDonnell Douglas Model DC–9–20, DC–9–30, DC–9–40, and DC–9–50 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0658)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4045. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; ZLT Zeppelin Luftschifftechnik GmbH and Co KG Model LZ N07–100 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0868)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4046. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A320 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0379)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4047. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model CL–600–2A12 (CL–601) and CL–600–2B16 (CL–601–3A, CL–601–3R, and CL–604) Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0565)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4048. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 747–100, 747–100B, 747–200B, 747–200C, and 747–200F, and 747SR Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0553)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4049. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model CL–600–2C10 (Regional Jet Series 700 and 701) Airplanes and CL–600–2D24 (Regional Jet Series 900) Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0436)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4050. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Learjet Inc. Model 45 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0719)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4051. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Twin Commander Aircraft LLC Models 690, 690A, and 690B Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0778)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4052. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; 328 Support Services GmbH (Dornier) Model 328–100 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1074)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4053. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Lockheed Model L–1011 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1022)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4054. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Honeywell International Inc. LTS101 Series Turboshaft and LTP101 Series Turboprop Engines'' ((RIN2120–AA64)(Docket No. FAA–2008–1019)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4055. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A330–200 and –300 Series Airplanes; and Model A340–200 and –300 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1092)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4056. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Removal of Regulations Allowing for Polished Frost'' ((RIN2120–AJ09)(Docket No. FAA–2007–29281)) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. KERRY, from the Committee on Foreign Relations, without amendment:

S. 705. A bill to reauthorize the programs of the Overseas Private Investment Corporation, and for other purposes (Rept. No. 111–107).

By Mr. KERRY, from the Committee on Foreign Relations, with an amendment in the nature of a substitute:

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 (Rept. No. 111–108).

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. KERRY (for himself, Mr. DURBIN, Mr. HARKIN, Mr. SCHUMER, Mr. MENENDEZ, Mr. BROWN, and Mr. KIRK):

S. 2882. A bill to amend the Internal Revenue Code of 1986 to modify the rules relating to the treatment of individuals as independent contractors or employees, and for other purposes; to the Committee on Finance.

By Mr. JOHANNS:

S. 2883. A bill to amend the Internal Revenue Code of 1986 to provide for the distribution of remaining balances in flexible spending arrangements upon termination from employment; to the Committee on Finance.

By Mr. LIEBERMAN (for himself, Ms. COLLINS, Mr. VOINOVICH, and Mr. AKAKA):

S. 2884. A bill to amend title 5, United States Code, to provide for the transportation of the dependents, remains, and effects of certain Federal employees who die

while performing official duties or as a result of the performance of official duties; to the Committee on Homeland Security and Governmental Affairs.

By Mr. LEMIEUX:

S.J. Res. 22. A joint resolution proposing an amendment to the Constitution of the United States relative to requiring a balanced budget and granting the President of the United States the power of line-item veto; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 418

At the request of Ms. KLOBUCHAR, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 418, a bill to require secondary metal recycling agents to keep records of their transactions in order to deter individuals and enterprises engaged in the theft and interstate sale of stolen secondary metal, and for other purposes.

S. 471

At the request of Mrs. MURRAY, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 471, a bill to amend the Education Sciences Reform Act of 2002 to require the Statistics Commissioner to collect information from coeducational secondary schools on such schools' athletic programs, and for other purposes.

S. 571

At the request of Mr. MENENDEZ, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 571, a bill to strengthen the Nation's research efforts to identify the causes and cure of psoriasis and psoriatic arthritis, expand psoriasis and psoriatic arthritis data collection, and study access to and quality of care for people with psoriasis and psoriatic arthritis, and for other purposes.

S. 583

At the request of Mr. PRYOR, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 583, a bill to provide grants and loan guarantees for the development and construction of science parks to promote the clustering of innovation through high technology activities.

S. 619

At the request of Mrs. FEINSTEIN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 765

At the request of Mr. NELSON of Nebraska, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 765, a bill to amend the Internal Revenue Code of 1986 to allow the Secretary of the Treasury to not impose a penalty for failure to disclose reportable transactions when there is reasonable cause for such failure, to modify such penalty, and for other purposes.

S. 941

At the request of Mr. CRAPO, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of S. 941, a bill to reform the Bureau of Alcohol, Tobacco, Firearms, and Explosives, modernize firearm laws and regulations, protect the community from criminals, and for other purposes.

S. 1067

At the request of Mr. FEINGOLD, the name of the Senator from Rhode Island (Mr. REED) 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. 1121

At the request of Mr. HARKIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1121, a bill to amend part D of title V of the Elementary and Secondary Education Act of 1965 to provide grants for the repair, renovation, and construction of elementary and secondary schools, including early learning facilities at the elementary schools.

S. 1389

At the request of Mr. NELSON of Nebraska, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1389, a bill to clarify the exemption for certain annuity contracts and insurance policies from Federal regulation under the Securities Act of 1933.

S. 1535

At the request of Mrs. FEINSTEIN, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1535, a bill to amend the Fish and Wildlife Act of 1956 to establish additional prohibitions on shooting wildlife from aircraft, and for other purposes.

S. 1611

At the request of Mr. GREGG, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 1611, a bill to provide collective bargaining rights for public safety officers employed by States or their political subdivisions.

S. 1749

At the request of Mrs. FEINSTEIN, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of S. 1749, a bill to amend title 18, United States Code, to prohibit the possession or use of cell phones and similar wireless devices by Federal prisoners.

S. 2729

At the request of Ms. STABENOW, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 2729, a bill to reduce greenhouse gas emissions from uncapped domestic sources, and for other purposes.

S. 2760

At the request of Mr. UDALL of New Mexico, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 2760, a bill to amend title 38, United States Code, to provide for an increase in the annual amount authorized to be appropriated to the Secretary of Veterans Affairs to carry out comprehensive service programs for homeless veterans.

S. 2781

At the request of Ms. MIKULSKI, the names of the Senator from Alaska (Mr. BEGICH) and the Senator from Maine (Ms. SNOWE) were added as cosponsors of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2812

At the request of Mr. BINGAMAN, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. 2812, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs, and for other purposes.

S. 2847

At the request of Mr. WHITEHOUSE, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 2847, a bill to regulate the volume of audio on commercials.

S. 2853

At the request of Mr. GREGG, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 2853, a bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the long-term fiscal stability and economic security of the Federal Government of the United States, and to expand future prosperity growth for all Americans.

S. 2869

At the request of Ms. LANDRIEU, the names of the Senator from California (Mrs. BOXER) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 2869, a bill to increase loan limits for small business concerns, to provide for low interest refinancing for small business concerns, and for other purposes.

S. RES. 316

At the request of Mr. MENENDEZ, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of amendment No. 2790 intended to be 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.

AMENDMENT NO. 2804

At the request of Mr. CORNYN, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of amendment No. 2804 intended to be 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.

AMENDMENT NO. 2827

At the request of Mr. TESTER, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 2827 intended to be 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.

AMENDMENT NO. 2878

At the request of Mr. CARDIN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of amendment No. 2878 intended to be 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.

AMENDMENT NO. 2903

At the request of Ms. SNOWE, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of amendment No. 2903 intended to be 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.

AMENDMENT NO. 2909

At the request of Mr. NELSON of Florida, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of amendment No. 2909 intended to be 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.

AMENDMENT NO. 2947

At the request of Ms. KLOBUCHAR, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of amendment No. 2947 intended to be 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.

AMENDMENT NO. 3037

At the request of Mr. JOHNSON, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 3037 intended to be 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.

AMENDMENT NO. 3119

At the request of Mr. WARNER, the names of the Senator from Arkansas (Mr. PRYOR), the Senator from Maryland (Ms. MIKULSKI), the Senator from Missouri (Mrs. MCCASKILL) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of amendment No. 3119 intended to be 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.

AMENDMENT NO. 3136

At the request of Mr. UDALL of New Mexico, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of amendment No. 3136 intended to be 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.

AMENDMENT NO. 3156

At the request of Mr. LAUTENBERG, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of amendment No. 3156 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.

AMENDMENT NO. 3203

At the request of Mr. BAYH, the names of the Senator from Massachusetts (Mr. KIRK) and the Senator from California (Mrs. BOXER) were added as cosponsors of amendment No. 3203 intended to be 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 Mr. KERRY (for himself, Mr. DURBIN, Mr. HARKIN, Mr. SCHUMER, Mr. MENENDEZ, Mr. BROWN, and Mr. KIRK):

S. 2882. A bill to amend the Internal Revenue Code of 1986 to modify the rules relating to the treatment of individuals as independent contractors or employees, and for other purposes; to the Committee on Finance.

Mr. KERRY. Mr. President, today I am introducing the Taxpayer Responsibility, Accountability and Consistency Act of 2009 which will provide a level playing field to America's workers to ensure they are afforded protections already in the law, such as workers' compensation, Social Security, Medicare, payment of overtime, unemployment compensation, and the minimum wage. This legislation is cosponsored by Senators DURBIN, HARKIN, SCHUMER, BROWN, MENENDEZ, and KIRK.

Under current law, employers are required to take certain actions on behalf of their employees including withholding income taxes, paying Social Security and Medicare taxes, paying for unemployment insurance, and providing a safe and nondiscriminatory workplace. Employers are not required to undertake these obligations for independent contractors. When workers are misclassified, businesses that play by the rules lose business to competitors that do not play by the rules and workers lose valuable rights and protections.

The Internal Revenue Service, IRS, currently uses a common law test to determine whether a worker is an employee or independent contractor. Unfortunately, a loophole exists which allows a business to escape liability for misclassifying employees as independent contractors. Furthermore, there is statutory prohibition on the IRS providing guidance through regulation on employee classification.

Federal and State revenue is lost when businesses misclassify their workers as independent contractors. A study estimated that, between 1996 and 2004, $34.7 billion of Federal tax revenues went uncollected due to the misclassification of workers and the tax loopholes that allow it. Recent GAO and Treasury Inspector General reports have cited misclassification as posing significant concerns for workers, their employers, and government revenue.

A study commissioned by the U.S. Department of Labor in 2000 found that up to 30 percent of firms misclassify their employees as independent contractors. State studies also show that misclassification is on the rise. In Massachusetts, the rate of misclassification has grown from 8.4 percent in 1995 through 1997 to a rate of 13.4 percent in 2001 through 2003.

Misclassification is more rampant than studies indicate. Studies cannot adequately capture the ''underground economy,'' where workers are paid off the books, often in cash. Unreported cash is one aspect of this problem and it is difficult for the IRS to discover because employers have no record of pay.

States have been leading the way in documenting and recovering taxes related to the misclassification of workers. In the Commonwealth of Massachusetts, Governor Deval Patrick has

tackled this issue head on and created an interagency task force on the underground economy and employee misclassification. The purpose of the task force is to gather information and assess current enforcement resources in an effort to improve current enforcement methods.

The Federal Government needs to follow the lead of the States by addressing the current safe harbor. The determination of whether an employer-employee relationship exists for federal tax purposes is made under a common-law test that has been incorporated into specific provisions of the Internal Revenue Code or is required to be used pursuant to Treasury regulations.

In 1987, based on an examination of cases and rulings, the Internal Revenue Service developed a list of 20 factors for determining whether an employer-employee relationship exists. The IRS recognizes that there may be relevant factors in addition to the 20 factors. Most recently, the IRS has structured its inquiry into three groupings: behavioral control, financial control, and the relationship of the worker and firm.

Section 530 of the Revenue Act of 1978 generally allows taxpayers to treat a worker as not being an employee for employment tax purposes, regardless of the worker's actual status under the common law test, unless the taxpayer has no reasonable basis for such treatment or fails to meet certain requirements. Section 530 is commonly referred to as a ''safe harbor.'' This provision was initially enacted for a year to give Congress time to resolve these complex issues. In 1982, the safe harbor provision was made permanent.

The Taxpayer Responsibility, Accountability and Consistency Act of 2009 would address the current loophole by requiring information reporting and making changes to the safe harbor. It would require businesses that pay any amount greater than $600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS. A similar provision has been proposed by both Presidents Obama and Bush. This provision will ensure that contractor income is accurately reported in order to prevent fraudulent underpayment of taxes.

The Taxpayer Responsibility, Accountability and Consistency Act of 2009 revises the safe harbor and makes it part of the Internal Revenue Code of 1986. The safe harbor would continue to be available to employers for purposes of shielding them from liability, but it will be narrowed to reduce abuses and to ensure they had a genuinely reasonable basis for not treating such individual as an employee. Under the Taxpayer Responsibility, Accountability and Consistency Act of 2009, an employer shall be treated as having a reasonable basis for treating an individual as an independent contractor only if the decision was based on a written determination by the IRS to the taxpayer addressing the employment status of such individual or another individual holding a substantially similar position with the taxpayer, or a concluded employment tax examination by the IRS.

The current safe harbor would continue to apply to services rendered up to one year after the date of enactment; after that, the new safe harbor would apply to services rendered more than one year after the date of enactment.

I urge my colleagues to cosponsor the Taxpayer Responsibility, Accountability and Consistency Act of 2009 which will provide valuable protections to workers who are erroneously misclassified and help combat the underground economy.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3219. Mr. CARDIN 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 3220. Mr. RISCH 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 3221. Mr. WYDEN (for himself and Mr. DURBIN) 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 3222. Mr. FEINGOLD 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 3223. Mr. CRAPO 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 3224. Mr. CRAPO 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 3225. Mr. LEMIEUX 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 3226. Mr. WHITEHOUSE 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 3227. Mr. CARDIN 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 3228. Ms. LANDRIEU (for herself, Mr. WARNER, and Mr. AKAKA) 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 3229. Mr. CRAPO 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 3230. Mr. CRAPO 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 3231. Mr. CRAPO 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 3232. Mr. BYRD 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 3233. Mr. BYRD 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 3234. Mr. CASEY 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 3235. Mr. CASEY (for himself and Mr. SPECTER) 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 3236. Mr. KOHL 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 3237. Mr. BURRIS 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 3238. Mr. ROCKEFELLER (for himself, Mr. KOHL, Mr. CARPER, and Mr. WARNER) 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 3239. Mr. ROCKEFELLER (for himself, Ms. COLLINS, and Mr. KOHL) 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 3240. Mr. ROCKEFELLER (for himself, Mr. LIEBERMAN, Mr. WHITEHOUSE, and Mr. BINGAMAN) 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 3241. Mr. CARPER (for himself, Mr. CONRAD, and Mrs. SHAHEEN) 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.

TEXT OF AMENDMENTS

SA 3219. Mr. CARDIN 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 396, between lines 8 and 9, insert the following:

Subtitle H—Patient Protections

PART I—IMPROVING MANAGED CARE

Subpart A—Utilization Review; Claims

SEC. 1601. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claims for such benefits without regard to whether and when a written confirmation of such request is made.

(b) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination.

(c) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (b) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination); and

(2) the procedures for obtaining additional information concerning the determination.

(d) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

Subpart B—Access to Care

SEC. 1611. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 1612. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must

provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 1613. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

(1) IN GENERAL.—A group health plan or health insurance issuer offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is a covered benefit under the plan or coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to require the coverage under a group health plan or health insurance coverage of benefits or services;

(B) to prohibit a plan or issuer from including providers in the network only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees;

(C) to override any State licensure or scope-of-practice law; or

(D) to override the normal community standards, taking into account the geographic location of such community, regarding timely access to specialists.

(3) ACCESS TO CERTAIN PROVIDERS.—

(A) IN GENERAL.—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a nonparticipating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) REFERRALS.—

(1) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a nonparticipating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan or health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition, if such specialist agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(c) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialty care be provided—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the case manager or primary care provider, and the participant, beneficiary, or enrollee, and

(ii) is approved by the plan or issuer in a timely manner, if the plan or issuer requires such approval; and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan or issuer from requiring the specialist to provide the plan or issuer with regular updates on the specialty care provided, as well as all other reasonably necessary medical information.

(d) SPECIALIST DEFINED.—For purposes of this section, the term ''specialist'' means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 1614. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

SEC. 1615. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(c) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 1616. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in subsection (e)(4)), or

(B) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage,

the plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient.

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall

apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved, or arrange to have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the right to elect continued transitional care from the provider under this section;

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

(4) CONTINUING CARE PATIENT.—For purposes of this section, the term ''continuing care patient'' means a participant, beneficiary, or enrollee who—

(A) is undergoing a course of treatment for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage termination described in paragraph (1) (or paragraph (2), if applicable);

(B) is undergoing a course of institutional or inpatient care from the provider at the time of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to a provider that was treating the terminal illness before the date of such notice.

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the surgery involved and post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(E) shall extend for the remainder of the patient's life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under this section upon the provider agreeing to the following terms and conditions:

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' or ''provider'' means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(3) SERIOUS AND COMPLEX CONDITION.—The term ''serious and complex condition'' means, with respect to a participant, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section (b)(2)(B)).

(4) TERMINATED.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Subpart C—Protecting the Doctor-Patient Relationship

SEC. 1621. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

Subpart D—Definitions

SEC. 1631. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this part in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this part under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this part under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this part:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this part, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan

under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(9) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

(10) TERMS AND CONDITIONS.—The term ''terms and conditions'' includes, with respect to a group health plan or health insurance coverage, requirements imposed under this part with respect to the plan or coverage.

SEC. 1632. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this part.

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this subtitle (except in the case of other substantially compliant requirements), in applying the requirements of this part under section 2720 and 2754 (as applicable) of the Public Health Service Act (as added by part II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' means a requirement under this part, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this part.

(B) SUBSTANTIALLY COMPLIANT.—The terms ''substantially compliant'', substantially complies'', or ''substantial compliance'' with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(c) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

(B) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved and the compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register the notice described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this subtitle become effective, as provided for in section 1652, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this part.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(d) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 1633. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this part. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this part.

SEC. 1634. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

The requirements of this part with respect to a group health plan or health insurance coverage are deemed to be incorporated into, and made a part of, such plan or the policy,

certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

PART II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 1641. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 1001, is further amended by adding at the end the following new section:

"SEC. 2720. PATIENT PROTECTION STANDARDS.

''Each group health plan shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act, and each health insurance issuer shall comply with patient protection requirements under such part with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2720)'' after ''requirements of such subparts''.

SEC. 1642. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2753 the following new section:

"SEC. 2754. PATIENT PROTECTION STANDARDS.

''Each health insurance issuer shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

SEC. 1643. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

"SEC. 2795. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

PART III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 1651. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 1562, is further amended by adding at the end the following new section:

"SEC. 716. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 1611 (relating to choice of health care professional).

''(B) Section 1612 (relating to access to emergency care).

''(C) Section 1613 (relating to timely access to specialists).

''(D) Section 1614 (relating to access to pediatric care).

''(E) Section 1615 (relating to patient access to obstetrical and gynecological care).

''(F) Section 1616 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(2) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of section 1621 of the Patient Protection and Affordable Care Act (relating to prohibition of interference with certain medical communications), the group health plan shall not be liable for such violation unless the plan caused such violation.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(4) TREATMENT OF SUBSTANTIALLY COMPLIANT STATE LAWS.—For purposes of applying this subsection, any reference in this subsection to a requirement in a section or other provision in subtitle H of title I of the Patient Protection and Affordable Care Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 1632(c) of such Act) with the requirement in such section or other provisions.

''(c) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subpart A of part I of subtitle H of title I of the Patient Protection and Affordable Care Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Patient protection standards''.

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this title, the provisions of this section (and the amendments made by this section) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this section (or amendments) shall not be treated as a termination of such collective bargaining agreement.

SEC. 1652. EFFECTIVE DATE.

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

SA 3220. Mr. RISCH 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:

Beginning on page 182, strike line 20 and all that follows through line 4 on page 183, and insert the following:

(3) STATE OPTION TO OPT-OUT OF NEW FEDERAL PROGRAM AND REQUIREMENTS.—

(A) IN GENERAL.—In accordance with this paragraph, a State may elect for the provisions of this Act to not apply within such State to the extent that such provisions violate the protections described in subparagraph (B).

(B) EFFECT OF OPT-OUT.—In the case of a State that makes an election under subparagraph (A)—

(i) the residents of such State shall not be subject to any requirement under this Act, including tax provisions or penalties, that would otherwise require such residents to purchase health insurance;

(ii) the employers located in such State shall not be subject to any requirement under this Act, including tax provisions or penalties, that would otherwise require such employers to provide health insurance to their employees or make contributions relating to health insurance;

(iii) the residents of such State shall not be prohibited under this Act from receiving health care services from any provider of health care services under terms and conditions subject to the laws of such State and mutually acceptable to the patient and the provider;

(iv) the residents of such State shall not be prohibited under this Act from entering into a contract subject to the laws of such State

with any group health plan, health insurance issuer, or other business, for the provision of, or payment to other parties for, health care services;

(v) the eligibility of residents of such State for any program operated by or funded wholly or partly by the Federal Government shall not be adversely affected as a result of having received services in a manner consistent with clauses (iii) and (iv);

(vi) the health care providers within such State shall not be denied participation in or payment from a Federal program for which they would otherwise be eligible as a result of having provided services in a manner consistent with clauses (iii) and (iv); and

(vii) States that elect to opt out shall not be subject to the taxes and fees enumerated in the amendments made by title IX.

(C) PROCESS.—

(i) IN GENERAL.—A State shall be treated as making an election under subparagraph (a) if—

(I) the Governor of such State provides timely and appropriate notice to the Secretary of Health and Human Services notifying the Secretary that the State is making such election; or

(II) such State enacts a law making such election.

Such notice shall be provided at least 180 days before the election is to become effective.

(ii) REVOCATION OF ELECTION.—A State shall be treated as revoking an election made by the State under subparagraph (A) if—

(I) the Governor of such State provides timely and appropriate notice to the Secretary of Health and Human Services of such revocation; or

(II) such State repeals a law described in subparagraph (i)(II).

Such notice of revocation shall be provided at least 180 days before the date the revocation is to become effective. As of such effective date the State and the residents, employers, and health insurance issuers of such State, shall be treated as if the election under subparagraph (A) had not been made.

SA 3221. Mr. WYDEN (for himself and Mr. DURBIN) 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 1203, between lines 16 and 17, insert the following:

SEC. 4109. IMPROVING ACCESS TO CLINICAL TRIALS.

(a) FINDINGS.—Congress finds the following:

(1) Advances in medicine depend on clinical trial research conducted at public and private research institutions across the United States.

(2) The challenges associated with enrolling participants in clinical research studies are especially difficult for studies that evaluate treatments for rare diseases and conditions (defined by the Orphan Drug Act as a disease or condition affecting fewer than 200,000 Americans), where the available number of willing and able research participants may be very small.

(3) In accordance with ethical standards established by the National Institutes of Health, sponsors of clinical research may provide payments to trial participants for out-of-pocket costs associated with trial enrollment and for the time and commitment demanded by those who participate in a study. When offering compensation, clinical trial sponsors are required to provide such payments to all participants.

(4) The offer of payment for research participation may pose a barrier to trial enrollment when such payments threaten the eligibility of clinical trial participants for Supplemental Security Income and Medicaid benefits.

(5) With a small number of potential trial participants and the possible loss of Supplemental Security Income and Medicaid benefits for many who wish to participate, clinical trial research for rare diseases and conditions becomes exceptionally difficult and may hinder research on new treatments and potential cures for these rare diseases and conditions.

(b) EXCLUSION FOR COMPENSATION FOR PARTICIPATION IN CLINICAL TRIALS FOR RARE DISEASES OR CONDITIONS.—

(1) EXCLUSION FROM INCOME.—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)) is amended—

(A) by striking ''and'' at the end of paragraph (24);

(B) by striking the period at the end of paragraph (25) and inserting ''; and''; and

(C) by adding at the end the following:

''(26) the first $2,000 received during a calendar year by such individual (or such spouse) as compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition (as defined in section 5(b)(2) of the Orphan Drug Act), but only if the clinical trial—

''(A) has been reviewed and approved by an institutional review board that is established—

''(i) to protect the rights and welfare of human subjects participating in scientific research; and

''(ii) in accord with the requirements under part 46 of title 45, Code of Federal Regulations; and

''(B) meets the standards for protection of human subjects as provided under part 46 of title 45, Code of Federal Regulations.''.

(2) EXCLUSION FROM RESOURCES.—Section 1613(a) of the Social Security Act (42 U.S.C. 1382b(a)) is amended—

(A) by striking ''and'' at the end of paragraph (15);

(B) by striking the period at the end of paragraph (16) and inserting ''; and''; and

(C) by inserting after paragraph (16) the following:

''(17) any amount received by such individual (or such spouse) which is excluded from income under section 1612(b)(26) (relating to compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition).''.

(3) MEDICAID EXCLUSION.—

(A) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)), as amended by section 2002(a), is amended by adding at the end the following:

''(15) EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first $2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1612(b)(26) shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.''.

(B) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)), as amended by section 2002(b), is amended by inserting ''(e)(15),'' before ''(l)(3)''.

(4) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is the earlier of—

(A) the effective date of final regulations promulgated by the Commissioner of Social Security to carry out this section and such amendments; or

(B) 180 days after the date of enactment of this Act.

(5) SUNSET PROVISION.—This section and the amendments made by this section are repealed on the date that is 5 years after the date of the enactment of this Act.

(c) STUDY AND REPORT.—

(1) STUDY.—Not later than 36 months after the effective date of this section, the Comptroller General of the United States shall conduct a study to evaluate the impact of this section on enrollment of individuals who receive Supplemental Security Income benefits under title XVI of the Social Security Act (referred to in this section as ''SSI beneficiaries'') in clinical trials for rare diseases or conditions. Such study shall include an analysis of the following:

(A) The percentage of enrollees in clinical trials for rare diseases or conditions who were SSI beneficiaries during the 3-year period prior to the effective date of this section as compared to such percentage during the 3-year period after the effective date of this section.

(B) The range and average amount of compensation provided to SSI beneficiaries who participated in clinical trials for rare diseases or conditions.

(C) The overall ability of SSI beneficiaries to participate in clinical trials.

(D) Any additional related matters that the Comptroller General determines appropriate.

(2) REPORT.—Not later than 12 months after completion of the study conducted under paragraph (1), the Comptroller General shall submit to Congress a report containing the results of such study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SA 3222. Mr. FEINGOLD 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 1525, between lines 21 and 22, insert the following:

(iv) USE OF EXISTING DATA AND STATISTICS AND NEW DATA AND METHODOLOGIES.—In carrying out the responsibilities described in subclauses (I) through (III) of clause (iii), the Institute designated under clause (i)(II) shall identify, select, and incorporate existing data and statistics as well as new data and methodologies that would synthesize, expand, augment, improve, and modernize statistical measures to provide more accurate, transparent, coherent, and comprehensive assessments.

SA 3223. Mr. CRAPO 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 553, between lines 14 and 15, insert the following:

SEC. 2721. INCREASED PAYMENTS TO PRIMARY CARE PRACTITIONERS UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

''(C) payment for primary care services (as defined in subsection (hh)(1)) furnished by physicians (or for services furnished by other health care professionals that would be primary care services under such section if furnished by a physician) at a rate not less than 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, or 100 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2012 and each subsequent year;''; and

(B) by adding at the end the following new subsection:

''(hh) INCREASED PAYMENT FOR PRIMARY CARE SERVICES.—For purposes of subsection (a)(13)(C):

''(1) PRIMARY CARE SERVICES DEFINED.—The term 'primary care services' means evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary).

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent for periods beginning with 2015 with respect to amounts described in subsection (cc)''; and

(2) by adding at the end the following new subsection:

''(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of June 16, 2009.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SA 3224. Mr. CRAPO 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 510, between lines 9 and 10, insert the following:

SEC. 2504. SUBMISSION OF DATA FOR PHYSICIAN ADMINISTERED DRUGS.

(a) EXTENSION FOR IMPLEMENTATION OF REQUIREMENT FOR HOSPITALS TO SUBMIT UTILIZATION DATA.—Section 1927(a)(7) of the Social Security Act (42 U.S.C. 1396r–8(a)(7)) is amended—

(1) in subparagraph (A), by inserting ''in non-hospital settings and on or after August 1, 2010, in hospitals'' after ''January 1, 2006,'';

(2) in subparagraph (B)(ii), by inserting ''in non-hospital settings and on or after August 1, 2010, in hospitals'' after ''January 1, 2008,''; and

(3) in subparagraph (C), by inserting ''(August 1, 2010, in the case of hospital information),'' after ''January 1, 2007,''.

(b) PROPORTIONAL REBATES FOR DUAL ELIGIBLE CLAIMS.—Section 1927(a)(7) of the Social Security Act (42 U.S.C. 1396r–8)(a)(7)) is amended by adding at the end the following new subparagraph:

''(E) TEMPORARY ADJUSTMENT TO REBATE CALCULATION FOR DUAL ELIGIBLE CLAIMS.—Only with respect to claims for rebates submitted by States to manufacturers during the 2-year period that begins on the date of enactment of this subparagraph, for purposes of calculating the amount of rebate under subsection (c) for a rebate period for a covered outpatient drug for which payment is made under a State plan or waiver under this title and under part B of title XVIII, the total number of units reported by the State of each dosage form and strength of each such drug paid for under the State plan or waiver under this title during such rebate period is deemed to be equal to the product of—

''(i) such total number of units of such drug for which payment is made under the State plan or waiver under this title and under part B of title XVIII; and

''(ii) the proportion (expressed as a percentage) that the amount the State paid for each dosage form and strength of such drug under the State plan or waiver under this title during such rebate period bears to the amount that the State would have paid for each dosage form and strength of such drug under the State plan or waiver under this title during such rebate period if the State were the sole payer for such dosage form and strength of such drug.''.

SA 3225. Mr. LEMIEUX 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 appropriate place in title VI, insert the following:

SEC. ____. ESTABLISHMENT OF OFFICE OF DEPUTY SECRETARY FOR HEALTH CARE FRAUD PREVENTION IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; APPOINTMENT AND POWERS OF DEPUTY SECRETARY.

(a) IN GENERAL.—There is hereby established in the Department of Health and Human Services the Office of the Deputy Secretary for Health Care Fraud Prevention (referred to in this section as the ''Office'').

(b) DUTIES OF THE OFFICE.—The Office shall—

(1) direct the appropriate implementation within the Department of Health and Human Services of health care fraud prevention and detection recommendations made by Federal Government and private sector antifraud and oversight entities;

(2) routinely consult with the Office of the Inspector General for the Department of Health and Human Services, the Attorney General, and private sector health care antifraud entities to identify emerging health care fraud issues requiring immediate action by the Office;

(3) through a fixed fee for implementation and maintenance plus results-based contingency fee contract entered into with an entity that has experience in designing and implementing antifraud systems in the financial sector and experience and knowledge of the various service delivery and reimbursement models of Federal health programs, provide for the design, development, and operation of a predictive model antifraud system (in accordance with subsection (d)) to analyze health care claims data in real-time to identify high risk claims activity, develop appropriate rules, processes, and procedures and investigative research approaches, in coordination with the Office of the Inspector General for the Department of Health and Human Services, based on the risk level assigned to claims activity, and develop a comprehensive antifraud database for health care activities carried out or managed by Federal health agencies;

(4) promulgate and enforce regulations relating to the reporting of data claims to the health care antifraud system developed under paragraph (3) by all Federal health agencies;

(5) establish thresholds, in consultation with the Office of the Inspector General of the Department of Health and Human Services and the Department of Justice—

(A) for the amount and extent of claims verified and designated as fraudulent, wasteful, or abusive through the fraud prevention system developed under paragraph (3) for excluding providers or suppliers from participation in Federal health programs; and

(B) for the referral of claims identified through the health care fraud prevention

system developed under paragraph (3) to law enforcement entities (such as the Office of the Inspector General, Medicaid Fraud Control Units, and the Department of Justice); and

(6) share antifraud information and best practices with Federal health agencies, health insurance issuers, health care providers, antifraud organizations, antifraud databases, and Federal, State, and local law enforcement and regulatory agencies.

(c) DEPUTY SECRETARY FOR HEALTH CARE FRAUD PREVENTION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services the position of Deputy Secretary for Health Care Fraud Prevention (referred to in this section as the ''Deputy Secretary''). The Deputy Secretary shall serve as the head of the Office, shall act as the chief health care fraud prevention and detection officer of the United States, and shall consider and direct the appropriate implementation of recommendations to prevent and detect health care fraud, waste, and abuse activities and initiatives within the Department.

(2) APPOINTMENT.—The Deputy Secretary shall be appointed by the President, by and with the advice and consent of the Senate, and serve for a term of 5 years, unless removed prior to the end of such term for cause by the President.

(3) POWERS.—Subject to oversight by the Secretary, the Deputy Secretary shall exercise all powers necessary to carry out this section, including the hiring of staff, entering into contracts, and the delegation of responsibilities to any employee of the Department of Health and Human Services or the Office appropriately designated for such responsibility.

(4) DUTIES.—

(A) IN GENERAL.—The Deputy Secretary shall—

(i) establish and manage the operation of the predictive modeling system developed under subsection (b)(3) to analyze Federal health claims in real-time to identify high risk claims activity and refer risky claims for appropriate verification and investigative research;

(ii) consider and order the appropriate implementation of fraud prevention and detection activities, such as those recommended by the Office of the Inspector General of the Department of Health and Human Services, the Government Accountability Office, MedPac, and private sector health care antifraud entities;

(iii) not later than 6 months after the date on which he or she is initially appointed, submit to Congress an implementation plan for the health care fraud prevention systems under subsection (d); and

(iv) submit annual performance reports to the Secretary and Congress that, at minimum, shall provide an estimate of the return on investment with respect to the system, for all recommendations made to the Deputy Secretary under this section, a description of whether such recommendations are implemented or not implemented, and contain other relevant performance metrics.

(B) ANALYSIS AND RECOMMENDATIONS.—The Deputy Secretary shall provide required strategies and treatments for claims identified as high risk (including a system of designations for claims, such as ''approve'', ''decline'', ''research'', and ''educate and pay'') to the Centers for Medicare & Medicaid Services, other Federal and State entities responsible for verifying whether claims identified as high risk are payable, should be automatically denied, or require further research and investigation.

(C) LIMITATION.—The Deputy Secretary shall not have any criminal or civil enforcement authority otherwise delegated to the Office of Inspector General of the Department of Health and Human Services or the Attorney General.

(5) REGULATIONS.—The Deputy Secretary shall promulgate and enforce such rules, regulations, orders, and interpretations as the Deputy Secretary determines to be necessary to carry out the purposes of this section. Such authority shall be exercised as provided under section 553 of title 5, United States Code.

(d) HEALTH CARE FRAUD PREVENTION SYSTEM.—

(1) IN GENERAL.—The fraud prevention system established under subsection (b)(3) shall be designed as follows:

(A) IN GENERAL.—The fraud prevention system shall—

(i) be holistic;

(ii) be able to view all provider and patient activities across all Federal health program payers;

(iii) be able to integrate into the existing health care claims flow with minimal effort, time, and cost;

(iv) be modeled after systems used in the Financial Services industry; and

(v) utilize integrated real-time transaction risk scoring and referral strategy capabilities to identify claims that are statistically unusual.

(B) MODULARIZED ARCHITECTURE.—The fraud prevention system shall be designed from an end-to-end modularized perspective to allow for ease of integration into multiple points along a health care claim flow (pre- or post-adjudication), which shall—

(i) utilize a single entity to host, support, manage, and maintain software-based services, predictive models, and solutions from a central location for the customers who access the fraud prevention system;

(ii) allow access through a secure private data connection rather than the installation of software in multiple information technology infrastructures (and data facilities);

(iii) provide access to the best and latest software without the need for upgrades, data security, and costly installations;

(iv) permit modifications to the software and system edits in a rapid and timely manner;

(v) ensure that all technology and decision components reside within the module; and

(vi) ensure that the third party host of the modular solution is not a party, payer, or stakeholder that reports claims data, accesses the results of the fraud prevention systems analysis, or is otherwise required under this section to verify, research, or investigate the risk of claims.

(C) PROCESSING, SCORING, AND STORAGE.—The platform of the fraud prevention system shall be a high volume, rapid, real-time information technology solution, which includes data pooling, data storage, and scoring capabilities to quickly and accurately capture and evaluate data from millions of claims per day. Such platform shall be secure and have (at a minimum) data centers that comply with Federal and State privacy laws.

(D) DATA CONSORTIUM.—The fraud prevention system shall provide for the establishment of a centralized data file (referred to as a ''consortium'') that accumulates data from all government health insurance claims data sources. Notwithstanding any other provision of law, Federal health care payers shall provide to the consortium existing claims data, such as Medicare's ''Common Working File'' and Medicaid claims data, for the purpose of fraud and abuse prevention. Such accumulated data shall be transmitted and stored in an industry standard secure data environment that complies with applicable Federal privacy laws for use in building medical waste, fraud, and abuse prevention predictive models that have a comprehensive view of provider activity across all payers (and markets).

(E) MARKET VIEW.—The fraud prevention system shall ensure that claims data from Federal health programs and all markets flows through a central source so the waste, fraud, and abuse system can look across all markets and geographies in health care to identify fraud and abuse in Medicare, Medicaid, the State Children's Health Program, TRICARE, and the Department of Veterans Affairs, holistically. Such cross-market visibility shall identify unusual provider and patient behavior patterns and fraud and abuse schemes that may not be identified by looking independently at one Federal payer's transactions.

(F) BEHAVIOR ENGINE.—The fraud prevention system shall ensure that the technology used provides real-time ability to identify high-risk behavior patterns across markets, geographies, and specialty group providers to detect waste, fraud, and abuse, and to identify providers that exhibit unusual behavior patterns. Behavior pattern technology that provides the capability to compare a provider's current behavior to their own past behavior and to compare a provider's current behavior to that of other providers in the same specialty group and geographic location shall be used in order to provide a comprehensive waste, fraud, and abuse prevention solution.

(G) PREDICTIVE MODEL.—The fraud prevention system shall involve the implementation of a statistically sound, empirically derived predictive modeling technology that is designed to prevent (versus post-payment detect) waste, fraud, and abuse. Such prevention system shall utilize historical transaction data, from across all Federal health programs and markets, to build and re-develop scoring models, have the capability to incorporate external data and external models from other sources into the health care predictive waste, fraud, and abuse model, and provide for a feedback loop to provide outcome information on verified claims so future system enhancements can be developed based on previous claims experience.

(H) CHANGE CONTROL.—The fraud prevention system platform shall have the infrastructure to implement new models and attributes in a test environment prior to moving into a production environment. Capabilities shall be developed to quickly make changes to models, attributes, or strategies to react to changing patterns in waste, fraud, and abuse.

(I) SCORING ENGINE.—The fraud prevention system shall identify high-risk claims by scoring all such claims on a real-time capacity prior to payment. Such scores shall then be communicated to the fraud management system provided for under subparagraph (J).

(J) FRAUD MANAGEMENT SYSTEM.—The fraud prevention system shall utilize a fraud management system, that contains workflow management and workstation tools to provide the ability to systematically present scores, reason codes, and treatment actions for high-risk scored transactions. The fraud prevention system shall ensure that analysts who review claims have the capability to access, review, and research claims efficiently, as well as decline or approve claims (payments) in an automated manner. Workflow management under this subparagraph shall be combined with the ability to utilize principles of experimental design to compare and measure prevention and detection rates between test and control strategies. Such strategy testing shall allow for continuous improvement and maximum effectiveness in keeping up with ever changing fraud and abuse patterns. Such system shall provide the capability to test different treatments or

actions randomly (typically through use of random digit assignments).

(K) DECISION TECHNOLOGY.—The fraud prevention system shall have the capability to monitor consumer transactions in real-time and monitor provider behavior at different stages within the transaction flow based upon provider, transaction and consumer trends. The fraud prevention system shall provide for the identification of provider and claims excessive usage patterns and trends that differ from similar peer groups, have the capability to trigger on multiple criteria, such as predictive model scores or custom attributes, and be able to segment transaction waste, fraud, and abuse into multiple types for health care categories and business types.

(L) FEEDBACK LOOP.—The fraud prevention system shall have a feedback loop where all Federal health payers provide pre-payment and post-payment information about the eventual status of a claim designated as ''Normal'', ''Waste'', ''Fraud'', ''Abuse'', or ''Education Required''. Such feedback loop shall enable Federal health agencies to measure the actual amount of waste, fraud, and abuse as well as the savings in the system and provide the ability to retrain future, enhanced models. Such feedback loop shall be an industry file that contains information on previous fraud and abuse claims as well as abuse perpetrated by consumers, providers, and fraud rings, to be used to alert other payers, as well as for subsequent fraud and abuse solution development.

(M) TRACKING AND REPORTING.—The fraud prevention system shall ensure that the infrastructure exists to ascertain system, strategy, and predictive model return on investment. Dynamic model validation and strategy validation analysis and reporting shall be made available to ensure a strategy or predictive model has not degraded over time or is no longer effective. Queue reporting shall be established and made available for population estimates of what claims were flagged, what claims received treatment, and ultimately what results occurred. The capability shall exist to complete tracking and reporting for prevention strategies and actions residing farther upstream in the health care payment flow. The fraud prevention system shall establish a reliable metric to measure the dollars that are never paid due to identification of fraud and abuse, as well as a capability to effectively test and estimate the impact from different actions and treatments utilized to detect and prevent fraud and abuse for legitimate claims. Measuring results shall include waste and abuse.

(N) OPERATING TENET.—The fraud prevention system shall not be designed to deny health care services or to negatively impact prompt-pay laws because assessments are late. The database shall be designed to speed up the payment process. The fraud prevention system shall require the implementation of constant and consistent test and control strategies by stakeholders, with results shared with Federal health program leadership on a quarterly basis to validate improving progress in identifying and preventing waste, fraud, and abuse. Under such implementation, Federal health care payers shall use standard industry waste, fraud, and abuse measures of success.

(2) COORDINATION.—The Deputy Secretary shall coordinate the operation of the fraud prevention system with the Department of Justice and other related Federal fraud prevention systems.

(3) OPERATION.—The Deputy Secretary shall phase-in the implementation of the system under this subsection beginning not later than 18 months after the date of enactment of this Act, through the analysis of a limited number of Federal health program claims. Not later than 5 years after such date of enactment, the Deputy Secretary shall ensure that such system is fully phased-in and applicable to all Federal health program claims.

(4) NON-PAYMENT OF CLAIMS.—The Deputy Secretary shall promulgate regulations to prohibit the payment of any health care claim that has been identified as potentially ''fraudulent'', ''wasteful'', or ''abusive'' until such time as the claim has been verified as valid.

(5) APPLICATION.—The system under this section shall only apply to Federal health programs (all such programs), including programs established after the date of enactment of this Act.

(6) REGULATIONS.—The Deputy Secretary shall promulgate regulations providing the maximum appropriate protection of personal privacy consistent with carrying out the Office's responsibilities under this section.

(e) PROTECTING PARTICIPATION IN HEALTH CARE ANTIFRAUD PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, no person providing information to the Secretary under this section shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew, or had reason to believe, that such information was false.

(2) CONFIDENTIALITY.—The Office shall, through the promulgation of regulations, establish standards for—

(A) the protection of confidential information submitted or obtained with regard to suspected or actual health care fraud;

(B) the protection of the ability of representatives the Office to testify in private civil actions concerning any such information; and

(C) the sharing by the Office of any such information related to the medical antifraud programs established under this section.

(f) PROTECTING LEGITIMATE PROVIDERS AND SUPPLIERS.—

(1) INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish procedures for the implementation of fraud and abuse detection methods under all Federal health programs (including the programs under titles XVIII, XIX, and XXI of the Social Security Act) with respect to items and services furnished by providers of services and suppliers that includes the following:

(A) In the case of a new applicant to be such a provider or supplier, a background check, and in the case of a supplier a site visit prior to approval of participation in the program and random unannounced site visits after such approval.

(B) Not less than 5 years after the date of enactment of this Act, in the case of a provider or supplier who is not a new applicant, re-enrollment under the program, including a new background check and, in the case of a supplier, a site-visit as part of the application process for such re-enrollment, and random unannounced site visits after such re-enrollment.

(2) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under paragraph (1) participate in any Federal health program.

(3) BACKGROUND CHECKS.—The Secretary shall determine the extent of the background check conducted under paragraph (1), including whether—

(A) a fingerprint check is necessary;

(B) a background check shall be conducted with respect to additional employees, board members, contractors or other interested parties of the provider or supplier; and

(C) any additional national background checks regarding exclusion from participation in Federal health programs (such as the program under titles XVIII, XIX, or XXI of the Social Security Act), including conviction of any felony, crime that involves an act of fraud or false statement, adverse actions taken by State licensing boards, bankruptcies, outstanding taxes, or other indications identified by the Inspector General of the Department of Health and Human Services are necessary.

(4) LIMITATION.—No payment may be made to a provider of services or supplier under any Federal health program if such provider or supplier fails to obtain a satisfactory background check under this subsection.

(5) FEDERAL HEALTH PROGRAM.—In this subsection, the term ''Federal health program'' means any program that provides Federal payments or reimbursements to providers of health-related items or services, or suppliers of such items, for the provision of such items or services to an individual patient.

(g) USE OF SAVINGS.—Notwithstanding any other provision on law, amounts remaining at the end of a fiscal year in the account for any Federal health program to which this section applies that the Secretary of Health and Human Services determines are remaining as a result of the fraud prevention activities applied under this section shall remain in such account and be used for such program for the next fiscal year.

(h) DEFINITION.—The term ''Federal health agency'' means the Department of Health and Human Services, the Department of Veterans Affairs, and any Federal agency with oversight or authority regarding the provision of any medical benefit, item, or service for which payment may be made under a Federal health care plan or contract.

SA 3226. Mr. WHITEHOUSE 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:

Beginning on page 2027, strike line 20 and all that follows through page 2029, line 4, and insert the following:

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—

(i) IN GENERAL.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be the sum of—

(I) the net premiums written with respect to Medicaid business that are taken into account during the calendar year, plus

(II) the net premiums written with respect to non-Medicaid business that are taken into account during the calendar year.

(ii) NET PREMIUMS WRITTEN WITH RESPECT TO MEDICAID BUSINESS.—

(I) IN GENERAL.—The net premiums written with respect to Medicaid business that are taken into account during the calendar year shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written with respect to Medicaid business during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $100,000,000	0 percent
More than $100,000,000 but not more than $150,000,000	25 percent
More than $150,000,000 but not more than $200,000,000	50 percent
More than $200,000,000	100 percent.

(II) MEDICAID BUSINESS.—For purposes of this section, net premiums written with respect to Medicaid business means, with respect to any covered entity, that portion of the net premiums written with respect to health insurance for United States health risks which are written with respect to individuals who are eligible for medical assistance under, and enrolled in, a State plan under title XIX of the Social Security Act or a waiver of such plan. Such amounts shall be reported separately by each covered entity in the report required under subsection (g).

(iii) NET PREMIUMS WRITTEN WITH RESPECT TO NON-MEDICAID BUSINESS.—

(I) IN GENERAL.—The net premiums written with respect to non-Medicaid business that are taken into account during the calendar year shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written with respect to non-Medicaid business during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000	50 percent
More than $50,000,000	100 percent.

(II) NON-MEDICAID BUSINESS.—For purpose of this section, the net premiums written with respect to non-Medicaid business means, with respect to any covered entity, the total amount of net premiums written with respect to health insurance for United States health risks less the net premiums written with respect to Medicaid business.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	The percentage of third party administration agreement fees that are taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $10,000,000	50 percent
More than $10,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) PERFORMANCE ADJUSTMENT TO ANNUAL FEE.—

(1) IN GENERAL.—The Secretary shall—

(A) in the case of a penalized covered entity, increase the fee determined under subsection (b) for a calendar year as provided in paragraph (3), and

(B) in the case of any other covered entity, reduce the fee determined under subsection (b) for a calendar year as provided in paragraph (4).

(2) PENALIZED COVERED ENTITY DESCRIBED.—

(A) IN GENERAL.—For purposes of this paragraph, the term ''penalized covered entity'' means a covered entity that the Secretary determines has failed to meet the key performance thresholds (established under subparagraph (B)) for the calendar year involved.

(B) KEY PERFORMANCE THRESHOLDS.—The key performance thresholds established under this subparagraph are as follows:

(i) MEDICAL LOSS RATIO THRESHOLD.—The covered entity has a medical loss ratio, as reported under section 2718(a)(1) of the Public Health Service Act, of not less than 85 percent. The Secretary, in consultation with the Secretary of Health and Human Services may increase, but not decrease, such percentage by regulation.

(ii) MAXIMUM FINANCIAL RESERVE THRESHOLD.—

(I) IN GENERAL.—The covered entity has a financial reserve which is not greater than the amount established under regulations by the Secretary, in consultation with the Secretary of Health and Human Services. The Secretary may establish different thresholds for different categories of covered entity under this section. The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish a uniform methodology for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

(II) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulation) to the Secretary and the Secretary of Health and Human Services containing such information about the financial reserves of the entity as the Secretary may require. The rules of subsection (g)(2) shall apply to the information required to be reported under this subclause.

(3) AMOUNT OF FEE INCREASE.—

(A) IN GENERAL.—In the case of a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be increased by the penalty amount.

(B) PENALTY AMOUNT.—

(i) IN GENERAL.—The penalty amount shall be the product of—

(I) the amount determined under subsection (b), and

(II) the sum of the amounts determined under subparagraphs (C) and (D).

(ii) LIMITATION.—The penalty amount shall not exceed 20 percent of the amount determined under subsection (b).

(C) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio threshold established under paragraph (2)(A), over

(ii) the medical loss ratio (expressed in decimal form) of the penalized covered entity.

(D) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the financial reserves of the penalized covered entity, over

(II) the maximum financial reserve threshold established under paragraph (2)(B)(ii), to

(ii) such maximum financial reserve threshold.

(4) REDUCTION IN FEE.—

(A) IN GENERAL.—

(i) AMOUNT OF REDUCTION.—In the case of any covered entity that is not a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be reduced by an amount equal to the product of—

(I) the sum of all penalty amounts assessed in the calendar year under paragraph (3), and

(II) the fee redistribution ratio.

(ii) LIMITATION.—The reduction under this paragraph shall not exceed 20 percent of the amount determined under subsection (b).

(B) FEE DISTRIBUTION RATIO.—For purposes of this paragraph, the fee redistribution ratio is the ratio of—

(i) the weighted net written premium amount of the covered entity, to

(ii) the aggregate of the weighted net written premium amount of all covered entities.

(C) WEIGHTED NET WRITTEN PREMIUM AMOUNT.—For purposes of this paragraph, the weighted net written premium amount with respect to any covered entity is the amount described in subsection (b)(1)(A)(i) with respect to such covered entity, increased by the product of—

(i) such amount, and

(ii) the product of 0.05 and the sum of the amounts determined under subparagraphs (D) and (E).

(D) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio (expressed as a percentage) of the covered entity, over

(ii) the medical loss ratio threshold established under paragraph (2)(A).

(E) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the maximum financial reserve threshold established under paragraph (2)(B)(ii), over

(II) the financial reserves of the covered entity, to

(ii) such maximum financial reserve threshold.

SA 3227. Mr. CARDIN 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 731, strike line 17 and all that follows through line 10 on page 732 and insert the following:

''(xix) Using commonly available and inexpensive technologies, including wireless and Internet-based tools, that have a demonstrated ability to improve patient outcomes or reduce health care costs, to simplify the complex management and treatment of chronic diseases for patients and health care providers.

''(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

''(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

''(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

''(iii) Whether the model provides for in-person contact with applicable individuals.

''(iv) Whether the model utilizes technology, such as electronic health records, wireless and Internet-based tools,''.

SA 3228. Ms. LANDRIEU (for herself, Mr. WARNER, and Mr. AKAKA) 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 396, between lines 8 and 9, insert the following:

SEC. 1563. PROVISIONS RELATED TO VISION BENEFITS.

(a) EXEMPTION FROM COMPREHENSIVE COVERAGE REQUIREMENT.—Section 2707 of the Public Health Service Act, as added by section 1201, is amended by adding at the end the following:

''(e) VISION ONLY.—This section shall not apply to a plan described in section 1311(d)(2)(B)(iii) of the Patient Protection and Affordable Care Act.''.

(b) ESSENTIAL HEALTH BENEFITS.—Section 1302 of this Act is amended—

(1) in subsection (b)(4)—

(A) by redesignating subparagraphs (G) and (H) as subparagraphs (H) and (I), respectively;

(B) by inserting after subparagraph (F) the following:

''(G) provide that if a plan described in section 1311(d)(2)(B)(iii) (relating to stand-alone vision benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J);''; and

(C) in subparagraph (I), as so redesignated, by striking ''(G)'' and inserting ''(H)''; and

(2) by striking ''paragraph (4)(H)'' each place such term appears and inserting ''paragraph (4)(I)''.

(c) OFFERING OF COVERAGE.—Section 1311(d)(2)(B) of this Act is amended by adding at the end the following:

''(iii) OFFERING OF STAND-ALONE VISION BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope vision benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric vision benefits meeting the requirements of section 1302(b)(1)(J)).''.

(d) REFUNDABLE CREDIT.—Section 36B(b) of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following:

''(F) SPECIAL RULE FOR PEDIATRIC VISION COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(iii) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric vision benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.''.

(e) REDUCED COST-SHARING.—Section 1402(c) of this Act is amended by adding at the end the following:

''(6) SPECIAL RULE FOR PEDIATRIC VISION PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(iii) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric vision benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).''.

SA 3229. Mr. CRAPO 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:

Beginning on page 510, strike line 10 and all that follows through page 515, line 11.

SA 3230. Mr. CRAPO 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 436, between lines 14 and 15, insert the following:

SEC. 2008. NON-APPLICATION OF MEDICAID EXPANSION MANDATES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), with respect to a State, any provision of this Act or amendment made by this Act that imposes on the State an expansion of coverage under the Medicaid program shall not apply to the State if such expansion would result in the State incurring costs for providing medical assistance to individuals enrolled under the State Medicaid program that are greater than the costs the State would have incurred if this Act and such amendments had not been enacted.

SA 3231. Mr. CRAPO 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 828, between lines 3 and 4, insert the following:

SEC. 3130. ENHANCED FMAP TO PROVIDE INCREASED PAYMENTS FOR PHYSICIANS' SERVICES AND INPATIENT HOSPITAL SERVICES FURNISHED IN RURAL AREAS.

Notwithstanding any other provision of law, if at any time after January 1, 2014, a State increases, by not less than the rate applicable under the Medicare program, the payment rates under its State Medicaid program for medical assistance consisting of physician services or inpatient hospital services that are furnished in rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) of the State, the Federal medical assistance percentage otherwise applicable to such expenditures shall be increased by an amount equal to 100 percent of the increase in such rates from the rates applicable under the State Medicaid program for fiscal year 2009.

SA 3232. Mr. BYRD 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 1356, strike line 3 and insert the following:

''(2) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to eligible entities that are located in

States that have high rates of dental health care disparities.

SA 3233. Mr. BYRD 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 94, between lines 3 and 4, insert the following:

''(4) SELECTION.—In selecting States to participate in the demonstration project under this subsection, the Secretary shall give priority to States that have populations with high rates of—

''(A) chronic diseases, with particular emphasis on inclusion of States that have populations with high rates of diabetes, hypertension, and cardiovascular disease;

''(B) smoking and use of tobacco products; or

''(C) obesity.''.

SA 3234. Mr. CASEY 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 764, between lines 2 and 3, insert the following:

''(i) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

''(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

''(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

''(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

''(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

''(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).''.

SA 3235. Mr. CASEY (for himself and Mr. SPECTER) 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 923, between lines 7 and 8, insert the following:

SEC. 3211. IMPROVEMENTS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p) of the Social Security Act, as added by section 3201, is amended—

(1) in paragraph (3)—

(A) by redesignating subparagraph (C) as subparagraph (D);

(B) in subparagraph (D), as so redesignated, by striking ''(A) or (B)'' and inserting ''(A), (B), or (C)'';

(C) by inserting after subparagraph (B) the following new subparagraph:

''(C) A county—

''(i) where the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for the year is greater than 45 percent (as determined by the Secretary); and

''(ii) that is located in a State in which the percentage of residents over the age of 65 is greater than 14 percent (as determined by the Secretary).'';

(D) by inserting after subparagraph (C) the following flush sentence:

''Such term shall not include any MA local area identified under subsection (o)(1).''; and

(2) in paragraph (5), by striking ''$5,000,000,000'' and inserting ''$7,000,000,000''.

SA 3236. Mr. KOHL 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 731, between lines 16 and 17, insert the following:

''(xix) Implementing the lean methodology through a network of provider systems across the country in varying geographic areas and across sites of care that offer a patient-centered approach to improving quality, reducing medical errors, and enhancing value to patients.

SA 3237. Mr. BURRIS 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 appropriate place in title III, insert the following:

SEC. ____. PERMITTING PHYSICAL THERAPY TO BE FURNISHED UNDER THE MEDICARE PROGRAM UNDER THE CARE OF A DENTIST.

(a) IN GENERAL.—Section 1861(p)(1) of the Social Security Act (42 U.S.C. 1395x(p)(1)) is amended by inserting ''(2),'' after ''(1),''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after the date of the enactment of this Act.

SA 3238. Mr. ROCKEFELLER (for himself, Mr. KOHL, Mr. CARPER, and Mr. WARNER) 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 2074, after line 25, add the following:

TITLE X—COVERAGE OF ADVANCE CARE PLANNING

SEC. 10001. MEDICARE, MEDICAID, AND CHIP COVERAGE.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 4103, is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (EE);

(ii) by adding ''and'' at the end of subparagraph (FF); and

(iii) by adding at the end the following new subparagraph:

''(GG) voluntary advance care planning consultation (as defined in subsection (iii)(1));''; and

(B) by adding at the end the following new subsection:

''Voluntary Advance Care Planning Consultation

''(iii)(1) Subject to paragraphs (3) and (4), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to subparagraphs (A) and (B) of paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed

decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3)(A) An initial preventive physical examination under subsection (ww), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

''(B) A voluntary advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5)(A) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

''(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

''(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

''(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

''(iv) is portable across care settings; and

''(v) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

''(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

''(i) the intensity of medical intervention if the patient is pulseless, apneic, or has serious cardiac or pulmonary problems;

''(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

''(iii) the use of antibiotics; and

''(iv) the use of artificially administered nutrition and hydration.''.

(2) PAYMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 4103(c)(2), is amended by inserting ''(2)(GG),'' after ''(2)(FF) (including administration of the health risk assessment),''.

(3) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by section 4103(d), is amended—

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P) by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(Q) in the case of advance care planning consultations (as defined in section 1861(iii)(1)), which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011 .

(b) MEDICAID.—

(1) MANDATORY BENEFIT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), as amended by section 2301(b), is amended in the matter preceding clause (i) by striking ''and (28)'' and inserting '', (28), and (29)''.

(2) MEDICAL ASSISTANCE.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2006, and 2301(a)(1), is amended—

(A) in subsection (a)—

(i) in paragraph (28), by striking ''and'' at the end;

(ii) by redesignating paragraph (29) as paragraph (30); and

(iii) by inserting after paragraph (28) the following new paragraph:

''(29) advance care planning consultations (as defined in subsection (z));''; and

(B) by inserting after subsection (y) the following new subsection:

''(z)(1) For purposes of subsection (a)(28), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders for life sustaining treatments or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3) A voluntary advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5) For purposes of this subsection, the term 'orders regarding life sustaining treatment' has the meaning given that term in section 1861(iii)(5).''.

(c) CHIP.—

(1) CHILD HEALTH ASSISTANCE.—Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj) is amended—

(A) by redesignating paragraph (28) as paragraph (29); and

(B) by inserting after paragraph (27), the following:

''(28) Voluntary advance care planning consultations (as defined in section 1905(z)).''.

(2) MANDATORY COVERAGE.—

(A) IN GENERAL.—Section 2103 of such Act (42 U.S.C. 1397cc), is amended—

(i) in subsection (a), in the matter preceding paragraph (1), by striking ''and (7)'' and inserting ''(7), and (9)''; and

(ii) in subsection (c), by adding at the end the following:

''(9) END-OF-LIFE CARE.—The child health assistance provided to a targeted low-income child shall include coverage of voluntary advance care planning consultations (as defined in section 1905(z) and at the same payment rate as the rate that would apply to such a consultation under the State plan under title XIX).''.

(B) CONFORMING AMENDMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C.

1397bb(a)(7)(B)) is amended by striking ''section 2103(c)(5)'' and inserting ''paragraphs (5) and (9) of section 2103(c)''.

(d) DEFINITION OF ADVANCE DIRECTIVE UNDER MEDICARE, MEDICAID, AND CHIP.—

(1) MEDICARE.—Section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(2) MEDICAID AND CHIP.—Section 1902(w)(4) of such Act (42 U.S.C. 1396a(w)(4)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(e) RULE OF CONSTRUCTION.—A voluntary advance care planning consultation described under any provision of this section or amendment made by this section shall be provided solely at the option of the applicable individual. Nothing in this section shall be construed to—

(1) require an individual to complete an advance directive, an order for life-sustaining treatment, or other advance care planning document;

(2) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits that such individual is entitled to receive through any program under titles XVIII, XIX, or XXI of the Social Security Act; or

(3) encourage or promote suicide or assisted suicide.

(f) EFFECTIVE DATE.—The amendments made by this section take effect January 1, 2010.

SEC. 10002. DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.

(a) IN GENERAL.—A health insurance issuer offering a qualified health plan—

(1) shall provide for the dissemination of information related to end-of-life planning to individuals seeking enrollment in qualified health plans offered through the Exchange;

(2) shall present such individuals with—

(A) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(B) information related to other planning tools; and

(3) shall not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under paragraph (2) shall not presume the withdrawal of treatment and shall include end-of-life planning information that includes options to maintain all or most medical interventions.

(b) CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(2) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health plan; or

(3) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(c) ADVANCED DIRECTIVE DEFINED.—In this section, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care.

(d) PROHIBITION ON THE PROMOTION OF ASSISTED SUICIDE.—

(1) IN GENERAL.—Subject to paragraph (3), information provided to meet the requirements of subsection (a)(2) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing, regardless of legality.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to apply to or affect any option to—

(A) withhold or withdraw of medical treatment or medical care;

(B) withhold or withdraw of nutrition or hydration; and

(C) provide palliative or hospice care or use an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(3) NO PREEMPTION OF STATE LAW.—Nothing in this section shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making.

SA 3239. Mr. ROCKEFELLER (for himself, Ms. COLLINS, and Mr. KOHL) 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 2074, after line 25, add the following:

TITLE X—ADVANCE CARE PLANNING AND COMPASSIONATE CARE

SECTION 10001. SHORT TITLE.

This title may be cited as the ''Advance Planning and Compassionate Care Act of 2009''.

SEC. 10002. DEFINITIONS.

In this title:

(1) ADVANCE CARE PLANNING.—The term ''advance care planning'' means the process of—

(A) determining an individual's priorities, values and goals for care in the future when the individual is no longer able to express his or her wishes;

(B) engaging family members, health care proxies, and health care providers in an ongoing dialogue about—

(i) the individual's wishes for care;

(ii) what the future may hold for people with serious illnesses or injuries;

(iii) how individuals, their health care proxies, and family members want their beliefs and preferences to guide care decisions; and

(iv) the steps that individuals and family members can take regarding, and the resources available to help with, finances, family matters, spiritual questions, and other issues that impact seriously ill or dying patients and their families; and

(C) executing and updating advance directives and appointing a health care proxy.

(2) ADVANCE DIRECTIVE.—The term ''advance directive'' means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.

(3) CHIP.—The term ''CHIP'' means the program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) END-OF-LIFE-CARE.—The term ''end-of-life care'' means all aspects of care of a patient with a potentially fatal condition, and includes care that is focused on specific preparations for an impending death.

(5) HEALTH CARE POWER OF ATTORNEY.—The term ''health care power of attorney'' means a legal document that identifies a health care proxy or decisionmaker for a patient who has the authority to act on the patient's behalf when the patient is unable to communicate his or her wishes for medical care on matters that the patient specifies when he or she is competent. Such term includes a durable power of attorney that relates to medical care.

(6) LIVING WILL.—The term ''living will'' means a legal document—

(A) used to specify the type of medical care (including any type of medical treatment, including life-sustaining procedures if that person becomes permanently unconscious or is otherwise dying) that an individual wants provided or withheld in the event the individual cannot speak for himself or herself and cannot express his or her wishes; and

(B) that requires a physician to honor the provisions of upon receipt or to transfer the care of the individual covered by the document to another physician that will honor such provisions.

(7) MEDICAID.—The term ''Medicaid'' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(8) MEDICARE.—The term ''Medicare'' means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(9) ORDERS FOR LIFE-SUSTAINING TREATMENT.—The term ''orders for life-sustaining treatment'' means a process for focusing a patients' values, goals, and preferences on current medical circumstances and to translate such into visible and portable medical orders applicable across care settings, including home, long-term care, emergency medical services, and hospitals.

(10) PALLIATIVE CARE.—The term ''palliative care'' means interdisciplinary care for individuals with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle A—Consumer and Provider Education

PART I—CONSUMER EDUCATION

Subpart A—National Initiatives

SEC. 10101. ADVANCE CARE PLANNING TELEPHONE HOTLINE.

(a) IN GENERAL.—Not later than January 1, 2011, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and operate directly, or by grant, contract, or interagency agreement, a 24-hour toll-free telephone hotline to provide consumer information regarding advance care planning, including—

(1) an explanation of advanced care planning and its importance;

(2) issues to be considered when developing an individual's advance care plan;

(3) how to establish an advance directive;

(4) procedures to help ensure that an individual's directives for end-of-life care are followed;

(5) Federal and State-specific resources for assistance with advance care planning; and

(6) hospice and palliative care (including their respective purposes and services).

(b) ESTABLISHMENT.—In carrying out the requirements under subsection (a), the Director of the Centers for Disease Control and Prevention may designate an existing 24-hour toll-free telephone hotline or, if no such service is available or appropriate, establish a new 24-hour toll-free telephone hotline.

SEC. 10102. ADVANCE CARE PLANNING INFORMATION CLEARINGHOUSES.

(a) EXPANSION OF NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

(1) DEVELOPMENT.—Not later than January 1, 2010, the Secretary shall develop an online clearinghouse to provide comprehensive information regarding advance care planning.

(2) MAINTENANCE.—The advance care planning clearinghouse, which shall be clearly identifiable and available on the homepage of the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website, shall be maintained and publicized by the Secretary on an ongoing basis.

(3) CONTENT.—The advance care planning clearinghouse shall include—

(A) any relevant content contained in the national public education campaign required under section 10104;

(B) content addressing—

(i) an explanation of advanced care planning and its importance;

(ii) issues to be considered when developing an individual's advance care plan;

(iii) how to establish an advance directive;

(iv) procedures to help ensure that an individual's directives for end-of-life care are followed; and

(v) hospice and palliative care (including their respective purposes and services); and

(C) available Federal and State-specific resources for assistance with advance care planning, including—

(i) contact information for any State public health departments that are responsible for issues regarding end-of-life care;

(ii) contact information for relevant legal service organizations, including those funded under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(iii) advance directive forms for each State; and

(D) any additional information, as determined by the Secretary.

(b) ESTABLISHMENT OF PEDIATRIC ADVANCE CARE PLANNING CLEARINGHOUSE.—

(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary, in consultation with the Assistant Secretary for Children and Families of the Department of Health and Human Services, shall develop an online clearinghouse to provide comprehensive information regarding pediatric advance care planning.

(2) MAINTENANCE.—The pediatric advance care planning clearinghouse, which shall be clearly identifiable on the homepage of the Administration for Children and Families website, shall be maintained and publicized by the Secretary on an ongoing basis.

(3) CONTENT.—The pediatric advance care planning clearinghouse shall provide advance care planning information specific to children with life-threatening illnesses or injuries and their families.

SEC. 10103. ADVANCE CARE PLANNING TOOLKIT.

(a) DEVELOPMENT.—Not later than July 1, 2010, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop an online advance care planning toolkit.

(b) MAINTENANCE.—The advance care planning toolkit, which shall be available in English, Spanish, and any other languages that the Secretary deems appropriate, shall be maintained and publicized by the Secretary on an ongoing basis and made available on the following websites:

(1) The Centers for Disease Control and Prevention.

(2) The Department of Health and Human Service's National Clearinghouse for Long-Term Care Information.

(3) The Administration for Children and Families.

(c) CONTENT.—The advance care planning toolkit shall include content addressing—

(1) common issues and questions regarding advance care planning, including individuals and resources to contact for further inquiries;

(2) advance directives and their uses, including living wills and durable powers of attorney;

(3) the roles and responsibilities of a health care proxy;

(4) Federal and State-specific resources to assist individuals and their families with advance care planning, including—

(A) the advance care planning toll-free telephone hotline established under section 10101;

(B) the advance care planning clearinghouses established under section 10102;

(C) the advance care planning toolkit established under this section;

(D) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(E) website links or addresses for State-specific advance directive forms; and

(5) any additional information, as determined by the Secretary.

SEC. 10104. NATIONAL PUBLIC EDUCATION CAMPAIGN.

(a) NATIONAL PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—Not later than January 1, 2011, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, directly or through grants, contracts, or interagency agreements, develop and implement a national campaign to inform the public of the importance of advance care planning and of an individual's right to direct and participate in their health care decisions.

(2) CONTENT OF EDUCATIONAL CAMPAIGN.—The national public education campaign established under paragraph (1) shall—

(A) employ the use of various media, including regularly televised public service announcements;

(B) provide culturally and linguistically appropriate information;

(C) be conducted continuously over a period of not less than 5 years;

(D) identify and promote the advance care planning information available on the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website and Administration for Children and Families website, as well as any other relevant Federal or State-specific advance care planning resources;

(E) raise public awareness of the consequences that may result if an individual is no longer able to express or communicate their health care decisions;

(F) address the importance of individuals speaking to family members, health care proxies, and health care providers as part of an ongoing dialogue regarding their health care choices;

(G) address the need for individuals to obtain readily available legal documents that express their health care decisions through advance directives (including living wills, comfort care orders, and durable powers of attorney for health care);

(H) raise public awareness regarding the availability of hospice and palliative care; and

(I) encourage individuals to speak with their physicians about their options and intentions for end-of-life care.

(3) EVALUATION.—

(A) IN GENERAL.—Not later than July 1, 2013, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a nationwide survey to evaluate whether the national campaign conducted under this subsection has achieved its goal of changing public awareness, attitudes, and behaviors regarding advance care planning.

(B) BASELINE SURVEY.—In order to evaluate the effectiveness of the national campaign, the Secretary shall conduct a baseline survey prior to implementation of the campaign.

(C) REPORTING REQUIREMENT.—Not later than December 31, 2013, the Secretary shall report the findings of such survey, as well as any recommendations that the Secretary determines appropriate regarding the need for continuation or legislative or administrative changes to facilitate changing public awareness, attitudes, and behaviors regarding advance care planning, to the appropriate committees of the Congress.

(b) REPEAL.—Section 4751(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note; Public Law 101–508) is repealed.

SEC. 10105. UPDATE OF MEDICARE AND SOCIAL SECURITY HANDBOOKS.

(a) MEDICARE & YOU HANDBOOK.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall update the online version of the ''Planning Ahead'' section of the Medicare & You Handbook to include—

(A) an explanation of advance care planning and advance directives, including—

(i) living wills;

(ii) health care proxies; and

(iii) after-death directives;

(B) Federal and State-specific resources to assist individuals and their families with advance care planning, including—

(i) the advance care planning toll-free telephone hotline established under section 10101;

(ii) the advance care planning clearinghouses established under section 10102;

(iii) the advance care planning toolkit established under section 10103;

(iv) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(v) website links or addresses for State-specific advance directive forms; and

(C) any additional information, as determined by the Secretary.

(2) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in paragraph (1) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

(b) SOCIAL SECURITY HANDBOOK.—The Commissioner of Social Security shall—

(1) not later than 60 days after the date of enactment of this Act, update the online version of the Social Security Handbook for

beneficiaries to include the information described in subsection (a)(1); and

(2) include such information in all paper and online versions of such handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

SEC. 10106. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated for the period of fiscal years 2010 through 2014—

(1) $195,000,000 to the Secretary to carry out sections 10101, 10102, 10103, 10104 and 10105(a); and

(2) $5,000,000 to the Commissioner of Social Security to carry out section 10105(b).

Subpart B—State and Local Initiatives

SEC. 10111. FINANCIAL ASSISTANCE FOR ADVANCE CARE PLANNING.

(a) LEGAL ASSISTANCE FOR ADVANCE CARE PLANNING.—

(1) DEFINITION OF RECIPIENT.—Section 1002(6) of the Legal Services Corporation Act (42 U.S.C. 2996a(6)) is amended by striking ''clause (A) of'' and inserting ''subparagraph (A) or (B) of''.

(2) ADVANCE CARE PLANNING.—Section 1006 of the Legal Services Corporation Act (42 U.S.C. 2996e) is amended—

(A) in subsection (a)(1)—

(i) by striking ''title, and (B) to make'' and inserting the following: ''title;

''(C) to make''; and

(ii) by inserting after subparagraph (A) the following:

''(B) to provide financial assistance, and make grants and contracts, as described in subparagraph (A), on a competitive basis for the purpose of providing legal assistance in the form of advance care planning (as defined in section 10002 of the Patient Protection and Affordable Care Act, and including providing information about State-specific advance directives, as defined in that section) for eligible clients under this title, including providing such planning to the family members of eligible clients and persons with power of attorney to make health care decisions for the clients; and''; and

(B) in subsection (b), by adding at the end the following:

''(2) Advance care planning provided in accordance with subsection (a)(1)(B) shall not be construed to violate the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).''.

(3) REPORTS.—Section 1008(a) of the Legal Services Corporation Act (42 U.S.C. 2996g(a)) is amended by adding at the end the following: ''The Corporation shall require such a report, on an annual basis, from each grantee, contractor, or other recipient of financial assistance under section 1006(a)(1)(B).''.

(4) AUTHORIZATION OF APPROPRIATIONS.—Section 1010 of the Legal Services Corporation Act (42 U.S.C. 2996i) is amended—

(A) in subsection (a)—

(i) by striking ''(a)'' and inserting ''(a)(1)'';

(ii) in the last sentence, by striking ''Appropriations for that purpose'' and inserting the following:

''(3) Appropriations for a purpose described in paragraph (1) or (2)''; and

(iii) by inserting before paragraph (3) (as designated by clause (ii)) the following:

''(2) There are authorized to be appropriated to carry out section 1006(a)(1)(B), $10,000,000 for each of fiscal years 2010, 2011, 2012, 2013, and 2014.''; and

(B) in subsection (d), by striking ''subsection (a)'' and inserting ''subsection (a)(1)''.

(5) EFFECTIVE DATE.—This subsection and the amendments made by this subsection take effect July 1, 2010.

(b) STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990 to provide advance care planning services to Medicare beneficiaries, personal representatives of such beneficiaries, and the families of such beneficiaries. Such services shall include information regarding State-specific advance directives and ways to discuss individual care wishes with health care providers.

(2) REQUIREMENTS.—

(A) AWARD OF GRANTS.—In making grants under this subsection for a fiscal year, the Secretary shall satisfy the following requirements:

(i) Two-thirds of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted the Uniform Health-Care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws and approved and recommended for enactment by all States at the annual conference of such commissioners in 1993.

(ii) One-third of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted a uniform form regarding orders regarding life sustaining treatment (as described in section 10002) or a comparable approach to advance care planning.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, a State shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the State is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No State shall be paid funds from a grant made under this subsection prior to July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2010 through 2014 for purposes of awarding grants to States under paragraph (1).

(c) MEDICAID TRANSFORMATION GRANTS FOR ADVANCE CARE PLANNING.—Section 1903(z) of the Social Security Act (42 U.S.C. 1396b(z)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title by making available to individuals enrolled in the State plan or under a waiver of such plan information regarding advance care planning (as defined in section 10002 of the Patient Protection and Affordable Care Act), including at time of enrollment or renewal of enrollment in the plan or waiver, through providers, and through such other innovative means as the State determines appropriate.'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(D) WORK PLAN REQUIRED FOR AWARD OF ADVANCE CARE PLANNING GRANTS.—Payment to a State under this subsection to adopt the innovative methods described in paragraph (2)(G) is conditioned on the State submitting to the Secretary an approved plan for expending the funds awarded to the State under this subsection.''; and

(3) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after clause (ii), the following new clause:

''(iii) $20,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by striking subparagraph (B), and inserting the following:

''(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States awarded a grant for fiscal year 2010, 2011, 2012, 2013, or 2014. Such method shall provide that—

''(i) 100 percent of such funds for each of fiscal years 2010 through 2014 shall be awarded to States that design programs to adopt the innovative methods described in paragraph (2)(G); and

''(ii) in no event shall a payment to a State awarded a grant under this subsection for fiscal year 2010 be made prior to July 1, 2010.''.

(d) ADVANCE CARE PLANNING COMMUNITY TRAINING GRANTS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)).

(2) REQUIREMENTS.—

(A) USE OF FUNDS.—Funds awarded to an area agency on aging under this subsection shall be used to provide advance care planning education and training opportunities for local aging service providers and organizations.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, an area agency on aging shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the agency is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No area agency on aging shall be paid funds from a grant made under this subsection prior to July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2010 through 2014 for purposes of awarding grants to area agencies on aging under paragraph (1).

(e) NONDUPLICATION OF ACTIVITIES.—The Secretary shall establish procedures to ensure that funds made available under grants awarded under this section or pursuant to amendments made by this section supplement, not supplant, existing Federal funding, and that such funds are not used to duplicate activities carried out under such grants or under other Federally funded programs.

SEC. 10112. GRANTS FOR PROGRAMS FOR ORDERS REGARDING LIFE SUSTAINING TREATMENT.

(a) IN GENERAL.—The Secretary shall make grants to eligible entities for the purpose of—

(1) establishing new programs for orders regarding life sustaining treatment in States or localities;

(2) expanding or enhancing an existing program for orders regarding life sustaining treatment in States or localities; or

(3) providing a clearinghouse of information on programs for orders for life sustaining treatment and consultative services

for the development or enhancement of such programs.

(b) AUTHORIZED ACTIVITIES.—Activities funded through a grant under this section for an area may include—

(1) developing such a program for the area that includes home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services within the area;

(2) securing consultative services and advice from institutions with experience in developing and managing such programs; and

(3) expanding an existing program for orders regarding life sustaining treatment to serve more patients or enhance the quality of services, including educational services for patients and patients' families or training of health care professionals.

(c) DISTRIBUTION OF FUNDS.—In funding grants under this section, the Secretary shall ensure that, of the funds appropriated to carry out this section for each fiscal year—

(1) at least two-thirds are used for establishing or developing new programs for orders regarding life sustaining treatment; and

(2) one-third is used for expanding or enhancing existing programs for orders regarding life sustaining treatment.

(d) DEFINITIONS.—In this section:

(1) The term ''eligible entity'' includes—

(A) an academic medical center, a medical school, a State health department, a State medical association, a multi-State taskforce, a hospital, or a health system capable of administering a program for orders regarding life sustaining treatment for a State or locality; or

(B) any other health care agency or entity as the Secretary determines appropriate.

(2) The term ''order regarding life sustaining treatment'' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

(A) is signed and dated by a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

(B) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

(C) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

(D) is portable across care settings; and

(E) may incorporate any advance directive (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)) if executed by the individual. .

(3) The term ''program for orders regarding life sustaining treatment'' means, with respect to an area, a program that supports the active use of orders regarding life sustaining treatment in the area.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2009 through 2014.

PART II—PROVIDER EDUCATION

SEC. 10121. PUBLIC PROVIDER ADVANCE CARE PLANNING WEBSITE.

(a) DEVELOPMENT.—Not later than January 1, 2010, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall establish a website for providers under Medicare, Medicaid, the Children's Health Insurance Program, the Indian Health Service (include contract providers) and other public health providers on each individual's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(b) MAINTENANCE.—The website, shall be maintained and publicized by the Secretary on an ongoing basis.

(c) CONTENT.—The website shall include content, tools, and resources necessary to do the following:

(1) Inform providers about the advance directive requirements under the health care programs described in subsection (a) and other State and Federal laws and regulations related to advance care planning.

(2) Educate providers about advance care planning quality improvement activities.

(3) Provide assistance to providers to—

(A) integrate advance directives into electronic health records, including oral directives; and

(B) develop and disseminate advance care planning informational materials for their patients.

(4) Inform providers about advance care planning continuing education requirements and opportunities.

(5) Encourage providers to discuss advance care planning with their patients of all ages.

(6) Assist providers' understanding of the continuum of end-of-life care services and supports available to patients, including palliative care and hospice.

(7) Inform providers of best practices for discussing end-of-life care with dying patients and their loved ones.

SEC. 10122. CONTINUING EDUCATION FOR PHYSICIANS AND NURSES.

(a) IN GENERAL.—Not later than January 1, 2012, the Secretary, acting through the Director of Health Resources and Services Administration, shall develop, in consultation with health care providers and State boards of medicine and nursing, a curriculum for continuing education that States may adopt for physicians and nurses on advance care planning and end-of-life care.

(b) CONTENT.—

(1) IN GENERAL.—The continuing education curriculum developed under subsection (a) for physicians and nurses shall, at a minimum, include—

(A) a description of the meaning and importance of advance care planning;

(B) a description of advance directives, including living wills and durable powers of attorney, and the use of such directives;

(C) palliative care principles and approaches to care; and

(D) the continuum of end-of-life services and supports, including palliative care and hospice.

(2) ADDITIONAL CONTENT FOR PHYSICIANS.—The continuing education curriculum for physicians developed under subsection (a) shall include instruction on how to conduct advance care planning with patients and their loved ones.

Subtitle B—Portability of Advance Directives; Health Information Technology

SEC. 10131. PORTABILITY OF ADVANCE DIRECTIVES.

(a) MEDICARE.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B), by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.'';

(2) in paragraph (3), by striking ''a written'' and inserting ''an''; and

(3) by adding at the end the following new paragraph:

''(5)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider of services, a Medicare Advantage organization, or a prepaid or eligible organization shall be given the same effect by that provider or organization as an advance directive validly executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advanced directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(b) MEDICAID.—Section 1902(w) of the Social Security Act (42 U.S.C. 1396a(w)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B)—

(i) by striking ''in the individual's medical record'' and inserting ''in a prominent part of the individual's current medical record''; and

(ii) by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.'';

(2) in paragraph (4), by striking ''a written'' and inserting ''an''; and

(3) by adding at the end the following paragraph:

''(6)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider or organization shall be given the same effect by that provider or organization as an advance directive validly

executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advance directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 2101(d)(2), 2101(e), and 6401(c), is further amended—

(1) by redesignating subparagraphs (G) through (N) as subparagraphs (H) through (O), respectively; and

(2) by inserting after subparagraph (F) the following:

''(G) Section 1902(w) (relating to advance directives).''.

(d) STUDY AND REPORT REGARDING IMPLEMENTATION.—

(1) STUDY.—The Secretary shall conduct a study regarding the implementation of the amendments made by subsections (a) and (b).

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsections (a), (b), and (c) shall apply to provider agreements and contracts entered into, renewed, or extended under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and to State plans under title XIX of such Act (42 U.S.C. 1396 et seq.) and State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.), on or after such date as the Secretary specifies, but in no case may such date be later than 1 year after the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsections (b) and (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 10132. STATE ADVANCE DIRECTIVE REGISTRIES; DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g) is amended by adding at the end the following:

''SEC. 399X. STATE ADVANCE DIRECTIVE REGISTRIES.

''(a) STATE ADVANCE DIRECTIVE REGISTRY.—In this section, the term 'State advance directive registry' means a secure, electronic database that—

''(1) is available free of charge to residents of a State; and

''(2) stores advance directive documents and makes such documents accessible to medical service providers in accordance with Federal and State privacy laws.

''(b) GRANT PROGRAM.—Beginning on July 1, 2010, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to eligible entities to establish and operate, directly or indirectly (by competitive grant or competitive contract), State advance directive registries.

''(c) ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall—

''(A) be a State department of health; and

''(B) submit to the Director an application at such time, in such manner, and containing—

''(i) a plan for the establishment and operation of a State advance directive registry; and

''(ii) such other information as the Director may require.

''(2) NO REQUIREMENT OF NOTATION MECHANISM.—The Secretary shall not require that an entity establish and operate a driver's license advance directive notation mechanism for State residents under section 399Y to be eligible to receive a grant under this section.

''(d) ANNUAL REPORT.—For each year for which an entity receives an award under this section, such entity shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the registry.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal year 2010 and each fiscal year thereafter.

''SEC. 399Y. DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

''(a) IN GENERAL.—Beginning July 1, 2010, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to States to establish and operate a mechanism for a State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

''(1) establish and operate a State advance directive registry under section 399X; and

''(2) submit to the Director an application at such time, in such manner, and containing—

''(A) a plan that includes a description of how the State will—

''(i) disseminate information about advance directives at the time of driver's license application or renewal;

''(ii) enable each State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license in a manner consistent with the notice on such a license indicating a driver's intent to be an organ donor; and

''(iii) coordinate with the State department of health to ensure that, if a State resident has an advance directive notice on his or her driver's license, the existence of such advance directive is included in the State registry established under section 399X; and

''(B) any other information as the Director may require.

''(c) ANNUAL REPORT.—For each year for which a State receives an award under this section, such State shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the mechanism.

''(d) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2010 and each fiscal year thereafter.''.

SEC. 10133. GAO STUDY AND REPORT ON ESTABLISHMENT OF NATIONAL ADVANCE DIRECTIVE REGISTRY.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the feasibility of a national registry for advance directives, taking into consideration the constraints created by the privacy provisions enacted as a result of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Comptroller General of the United States determines to be appropriate.

Subtitle C—National Uniform Policy on Advance Care Planning

SEC. 10141. STUDY AND REPORT BY THE SECRETARY REGARDING THE ESTABLISHMENT AND IMPLEMENTATION OF A NATIONAL UNIFORM POLICY ON ADVANCE DIRECTIVES.

(a) STUDY.—

(1) IN GENERAL.—The Secretary, acting through the Office of the Assistant Secretary for Planning and Evaluation, shall conduct a thorough study of all matters relating to the establishment and implementation of a national uniform policy on advance directives for individuals receiving items and services under titles XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.; 1397aa et seq.).

(2) MATTERS STUDIED.—The matters studied by the Secretary under paragraph (1) shall include issues concerning—

(A) family satisfaction that a patient's wishes, as stated in the patient's advance directive, were carried out;

(B) the portability of advance directives, including cases involving the transfer of an individual from 1 health care setting to another;

(C) immunity from civil liability and criminal responsibility for health care providers that follow the instructions in an individual's advance directive that was validly executed in, and consistent with the laws of, the State in which it was executed;

(D) conditions under which an advance directive is operative;

(E) revocation of an advance directive by an individual;

(F) the criteria used by States for determining that an individual has a terminal condition;

(G) surrogate decisionmaking regarding end-of-life care;

(H) the provision of adequate palliative care (as defined in paragraph (3)), including pain management;

(I) adequate and timely referrals to hospice care programs; and

(J) the end-of-life care needs of children and their families.

(3) PALLIATIVE CARE.—For purposes of paragraph (2)(H), the term ''palliative care'' means interdisciplinary care for individuals

with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

(b) REPORT TO CONGRESS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) CONSULTATION.—In conducting the study and developing the report under this section, the Secretary shall consult with the Uniform Law Commissioners, and other interested parties.

Subtitle D—Compassionate Care Workforce Development

SEC. 10151. EXEMPTION OF PALLIATIVE MEDICINE FELLOWSHIP TRAINING FROM MEDICARE GRADUATE MEDICAL EDUCATION CAPS.

(a) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(F)), as amended by section 5503(a)(1), is amended—

(1) in clause (i), by inserting ''clause (iii) and'' after ''subject to''; and

(2) by adding at the end the following new clause:

''(iii) INCREASE ALLOWED FOR PALLIATIVE MEDICINE FELLOWSHIP TRAINING.—For cost reporting periods beginning on or after January 1, 2011, in applying clause (i), there shall not be taken into account full-time equivalent residents in the field of allopathic or osteopathic medicine who are in palliative medicine fellowship training that is approved by the Accreditation Council for Graduate Medical Education.''.

(b) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by sections 5503(b)(2) and 5505(b), is further amended by adding at the end the following new clause:

''(xi) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.''.

SEC. 10152. MEDICAL SCHOOL CURRICULA.

(a) IN GENERAL.—The Secretary, in consultation with the Association of American Medical Colleges, shall establish guidelines for the imposition by medical schools of a minimum amount of end-of-life training as a requirement for obtaining a Doctor of Medicine degree in the field of allopathic or osteopathic medicine.

(b) TRAINING.—Under the guidelines established under subsection (a), minimum training shall include—

(1) training in how to discuss and help patients and their loved ones with advance care planning;

(2) with respect to students and trainees who will work with children, specialized pediatric training;

(3) training in the continuum of end-of-life services and supports, including palliative care and hospice;

(4) training in how to discuss end-of-life care with dying patients and their loved ones; and

(5) medical and legal issues training.

(c) DISTRIBUTION.—Not later than January 1, 2011, the Secretary shall disseminate the guidelines established under subsection (a) to medical schools.

(d) COMPLIANCE.—Effective beginning not later than July 1, 2012, a medical school that is receiving Federal assistance shall be required to implement the guidelines established under subsection (a). A medical school that the Secretary determines is not implementing such guidelines shall not be eligible for Federal assistance.

Subtitle E—Additional Reports, Research, and Evaluations

SEC. 10161. NATIONAL MORTALITY FOLLOWBACK SURVEY.

(a) IN GENERAL.—Not later than December 31, 2010, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall renew and conduct the National Mortality Followback Survey (referred to in this section as the ''Survey'') to collect data on end-of-life care.

(b) PURPOSE.—The purpose of the Survey shall be to gain a better understanding of current end-of-life care in the United States.

(c) QUESTIONS.—

(1) IN GENERAL.—In conducting the Survey, the Director of the Centers for Disease Control and Prevention shall, at a minimum, include the following questions with respect to the loved one of a respondent:

(A) Did he or she have an advance directive, and if so, when it was completed.

(B) Did he or she have an order for life-sustaining treatment, and if so, when was it completed.

(C) Did he or she have a durable power of attorney, and if so, when it was completed.

(D) Had he or she discussed his or her wishes with loved ones, and if so, when.

(E) Had he or she discussed his or her wishes with his or her physician, and if so, when.

(F) In the opinion of the respondent, was he or she satisfied with the care he or she received in the last year of life and in the last week of life.

(G) Was he or she cared for by hospice, and if so, when.

(H) Was he or she cared for by palliative care specialists, and if so, when.

(I) Did he or she receive effective pain management (if needed).

(J) What was the experience of the main caregiver (including if such caregiver was the respondent), and whether he or she received sufficient support in this role.

(2) ADDITIONAL QUESTIONS.—Additional questions to be asked during the Survey shall be determined by the Director of the Centers for Disease Control and Prevention on an ongoing basis with input from relevant research entities.

SEC. 10162. INSPECTOR GENERAL INVESTIGATION OF FRAUD AND ABUSE.

In accordance with the recommendations of the Medicare Payment Advisory Commission for additional data (as contained in the March 2009 report entitled ''Report to Congress: Medicare Payment Policy''), the Secretary shall direct the Office of the Inspector General of the Department of Health and Human Services to investigate, not later than January 1, 2012, the following with respect to hospice benefit under Medicare, Medicaid, and CHIP:

(1) The prevalence of financial relationships between hospices and long-term care facilities, such as nursing facilities and assisted living facilities, that may represent a conflict of interest and influence admissions to hospice.

(2) Differences in patterns of nursing home referrals to hospice.

(3) The appropriateness of enrollment practices for hospices with unusual utilization patterns (such as high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices).

(4) The appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

SEC. 10163. GAO STUDY AND REPORT ON PROVIDER ADHERENCE TO ADVANCE DIRECTIVES.

Not later than January 1, 2012, the Comptroller General of the United States shall conduct a study of the extent to which providers comply with advance directives under the Medicare and Medicaid programs and shall submit a report to Congress on the results of such study, together with such recommendations for administrative or legislative changes as the Comptroller General determines appropriate.

SA 3240. Mr. ROCKEFELLER (for himself, Mr. LIEBERMAN, Mr. WHITEHOUSE, and Mr. BINGAMAN) 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 1053, between lines 2 and 3, insert the following:

SEC. 3403A. IMPROVEMENTS TO THE INDEPENDENT MEDICARE ADVISORY BOARD.

Section 1899A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (2)(A), by striking clause (iii) and inserting the following new clause:

''(iii) As appropriate, the proposal may include recommendations to adjust payments with respect to all providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)).'';

(B) in paragraph (3)(A)(ii)—

(i) in subclause (I), by inserting ''or'' at the end;

(ii) in subclause (II), by striking ''; or'' at the end and inserting a period; and

(iii) by striking subclause (III);

(C) in paragraph (7)(C), by striking clause (i) and inserting the following new clause:

''(i) in the case of implementation year 2015 or any subsequent implementation year, 1.5 percent; and''; and

(D) by striking paragraph (8);

(2) in subsection (e), by striking ''August 15'' each place it appears and inserting ''June 1'';

(3) in subsection (f)(3)(B), by striking ''or advisory reports to Congress'' and inserting '', advisory reports, or other reports'';

(4) by redesignating subsections (g) through (m) as subsections (i) through (o), respectively; and

(5) by adding at the end the following new subsections:

''(g) PROPOSALS IN NON-DETERMINATION YEARS.—

''(1) IN GENERAL.—In any proposal year in which the Board is not required to transmit a proposal to the President by reason of the application of subclause (I) or (II) of subsection (c)(3)(A)(ii), the Board shall transmit a proposal under this section to the President on January 15 of the year. Except as provided in paragraph (2), such a proposal shall be treated as a proposal under this section and all of the provisions of this section with respect to proposals, including the requirements under paragraphs (2) and (4) of subsection (c) and the required Congressional consideration under subsection (d), shall apply to the proposal.

''(2) EXCEPTIONS.—The following rules shall apply to a proposal transmitted pursuant to paragraph (1):

''(A) RECOMMENDATIONS FOR ACHIEVING TARGET.—The requirement under subsection (c)(2)(A)(i) shall not apply.

''(B) REQUIRED INFORMATION.—The proposal shall not include—

''(i) recommendations described in subsection (c)(2)(A)(i), pursuant to subsection (c)(3)(B)(i); or

''(ii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subsection (c)(2)(A)(i), pursuant to subsection (c)(3)(B)(iii);

''(C) CONTINGENT SECRETARIAL PROPOSAL.—The Secretary shall not submit a proposal if the Board fails to submit a proposal pursuant to subsection (c)(5).

''(D) CONGRESSIONAL CONSIDERATION.—

''(i) Subparagraphs (A) and (B) of subsection (d)(3) shall be applied by substituting 'subsection (c)(2)(C)' for 'subparagraphs (A)(i) and (C) of subsection (c)(2)'.

''(ii) Subparagraphs (D) and (E) of subsection (d)(3) and subsection (d)(4)(B)(v) shall be applied by requiring a simple majority rather than three-fifths of the Members duly chosen and sworn.

''(iii) Subsection (d)(4)(B)(iv) shall not apply.

''(iv) Subsection (d)(4)(C)(v)(II) shall be applied by substituting 'subsection (c)(2)(C)' for 'subparagraphs (A)(i) and (C) of subsection (c)(2)'.

''(v) Subsection (d)(4)(E)(iv)(II) shall be applied by substituting 'subsection (c)(2)(C)' for 'subparagraphs (A)(i) and (C) of subsection (c)(2)'.

''(E) SECRETARIAL IMPLEMENTATION.—Subsection (e) shall not apply and the Secretary shall not implement the recommendations contained in the proposal unless the Secretary otherwise has the authority to implement such recommendations.

''(h) ANNUAL REPORT WITH RECOMMENDATIONS WITH RESPECT TO THE PRIVATE SECTOR.—

''(1) IN GENERAL.—Not later than July 1, 2014, and January 15, 2015, and annually thereafter, the Board shall submit to Congress, the Secretary, and the Medicaid and CHIP Payment and Access Commission a report that includes recommendations on—

''(A) requirements under the program under this title (or requirements included in the proposal submitted under this section in the year); and

''(B) in the case of any report submitted in a year after a determination year (beginning with determination year 2017) in which the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subclause (I) or (II) of subsection (c)(3)(A)(ii), other requirements determined appropriate by the Board;

that should be included in the requirements established under section 1311(c) of the Patient Protection and Affordable Care Act for a health plan to be certified as a qualified health plan, such as requirements that improve the health care delivery system and health outcomes (including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency), decrease health care spending, and other appropriate improvements

''(2) INCORPORATION INTO CERTIFICATION REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall review the recommendations contained in the report submitted to the Secretary by the Board under paragraph (1). The Secretary may, if determined appropriate, incorporate such recommendations into the requirements for certification under such section 1311(c).

''(B) REPORT TO CONGRESS.—Not later than December 31, 2014, and June 15, 2015, and annually thereafter, the Secretary shall submit to Congress a report on the application of subparagraph (A). Such report shall include, with respect to each recommendation contained in a report submitted by the Board in that year, a description of whether or not the Secretary incorporated the recommendation into the requirements for certification under such section 1311(c), and if not, the reasons why.

''(3) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall—

''(A) review whether or not recommendations contained in a report submitted to the Commission by the Board under paragraph (1) would improve the Medicaid program under title XIX and the Children's Health Insurance Program under title XXI if implemented under such programs; and

''(B) include in the Commission's annual report to Congress the results of such review.''.

SA 3241. Mr. CARPER (for himself, Mr. CONRAD, and Mrs. SHAHEEN) 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 722, after line 20, insert the following:

SEC. 3016. INTEGRATED HEALTH CARE SYSTEM COLLABORATION INITIATIVE.

(a) IN GENERAL.—In order to improve health care quality and reduce costs, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop, in consultation with major integrated health systems that have consistently demonstrated high quality and low cost (as determined by the Secretary and verified by a third party) a collaboration initiative (referred to in this section as ''the Collaborative''). The Collaborative shall develop an exportable model of optimal health care delivery to apply value-based measurement, integrated information technology infrastructure, standard care pathways, and population-based payment models, to measurably improve health care quality, outcomes, and patient satisfaction and achieve cost savings.

(b) PARTICIPATION.—Prior to January 1, 2010, the Secretary shall determine 5 initial participants who will form the Collaborative and at least 6 additional participants who will join the Collaborative beginning in the fourth year that the Collaborative is in effect.

(1) INITIAL PARTICIPANTS.—Initial participants selected by the Secretary shall meet the following criteria:

(A) Be integrated health systems organized for the purpose of providing health care services.

(B) Have demonstrated a record of providing high value health care for at least the 5 previous years, as determined by the Secretary in consultation with the Medicare Payment Advisory Commission.

(C) Agree to participate in the Medicare shared savings program under section 1899 of the Social Security Act, as added by section 3022, the National pilot program on payment bundling under section 1866D of such Act, as added by section 3023, or a program under the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

(D) Any additional criteria specified by the Secretary.

(2) ADDITIONAL PARTICIPANTS.—Beginning January 1, 2013, the Secretary shall select 6 or more additional participants who represent diverse geographic areas and are situated in areas of differing population densities who agree to comply with the guidelines, processes, and requirements set forth for the Collaborative. Such additional participants shall meet the following additional criteria:

(A) Be organized for the provision of patient medical care.

(B) Be capable of implementing infrastructure and health care delivery modifications necessary to enhance health care quality and efficiency, as determined by the Secretary in consultation with the Medicare Payment Advisory Commission.

(C) The participant's cost and intensity of care do not meet the definition of high value health care.

(D) Agree to participate in the Medicare shared savings program under section 1899 of the Social Security Act, as added by section 3022, the National pilot program on payment bundling under section 1866D of such Act, as added by section 3023, or a program under the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

(E) The participant would benefit from such participation (as determined by the Secretary, based on the likelihood that the participant would improve its performance under section 1886(p) of the Social Security Act, as added by section 3008, section 1886(q) of such Act, as added by section 3025, or any similar program under title XVIII of the Social Security Act).

(3) ADDITIONAL CRITERIA.—In addition to the criteria described in paragraphs (1) and (2), the participants in the Collaborative shall meet the following criteria:

(A) Agree to report on quality, cost, and efficiency in such form, manner, and frequency as specified by the Secretary.

(B) Provide care to patients enrolled in the Medicare program.

(C) Agree to contribute to a best practices network and website, that is maintained by the Collaborative for sharing strategies on quality improvement, care coordination, efficiency, and effectiveness.

(D) Use patient-centered processes of care, including those that emphasize patient and caregiver involvement in shared decision-making for treatment decisions.

(E) Meet other criteria determined to be appropriate by the Secretary.

(c) COLLABORATIVE INITIATIVE.—

(1) IN GENERAL.—Beginning January 1, 2010, the Collaborative shall begin a 2 year development phase in which initial participants share the quantitative and qualitative methods through which they have developed high value health care followed by a dissemination of that learning model to additional participants of the Collaborative.

(2) COORDINATING MEMBER.—In consultation with the Secretary, the Collaborative shall select a coordinating member organization (hereafter identified as the Coordinating Organization) of the Collaborative.

(3) QUALIFICATIONS.—The Coordinating Organization will have in place a comprehensive Medicare database and possess experience using and analyzing Medicare data to measure health care utilization, cost, and variation. The Coordinating Organization shall be responsible for reporting to the Secretary as required and for any other requirements deemed necessary by the Secretary.

(4) RESPONSIBILITIES.—The Coordinating Member shall—

(A) lead efforts to develop each aspect of the learning model;

(B) organize efforts to disseminate the learning model for high value health care, including educating participant institutions; and

(C) provide administrative, technical, accounting, reporting, organizational and infrastructure support needed to carry out the goals of the Collaborative.

(5) DEVELOPMENT OF LEARNING MODEL.—

(A) IN GENERAL.—Initial participants in the Collaborative shall work together to develop a learning model based on their experience that includes a reliance on evidence based care that emphasizes quality and practice techniques that emphasize efficiency, joint development and implementation of health information technology, introduction of clinical microsystems of care, shared decision-making, outcomes and measurement, and the establishment of an e-learning distributive network, which have been put into practice at their respective institutions.

(B) RESPONSIBILITIES.—The Coordinating Member shall do the following:

(i) Partner with initial participants to comprehensively understand each institution's contribution to providing value-based health care.

(ii) Provide and measure value-based health care in a manner that ensures that measures are aligned with current measures approved by a consensus-based organization, such as the National Quality Forum, or other measures as determined appropriate by the Secretary, while also incorporating patient self-reported status and outcomes.

(iii) Create a replicable and scalable infrastructure for common measurement of value-based care that can be broadly disseminated across the Collaborative and other institutions.

(iv) Implement care pathways for common conditions using standard measures for assessment across institutions, targeting high variation and high cost conditions, including but not limited to—

(I) acute myocardial infarction (AMI) and angioplasty;

(II) coronary artery bypass graft surgery and percutaneous coronary intervention;

(III) hip or knee replacement;

(IV) spinal surgery; and

(V) care for chronic diseases including, but not limited to, diabetes, heart disease, and high blood pressure.

(v) Deploy and disseminate the comprehensive learning model across initial participant institutions, achieving improvements in care delivery and lowering costs, and demonstrating the portability and viability of the processes.

(6) ADDITIONAL BEST PRACTICES.—As additional methods of improving health care quality and efficiency are identified by members of the Collaborative or by other institutions, Initial Participants in the Collaborative shall incorporate those practices into the learning model.

(d) IMPLEMENTATION OF LEARNING MODEL.—Beginning January 1, 2013, as additional participants are selected by the Secretary, Initial Participants in the Collaborative shall actively engage in the deployment of the learning model to educate each additional participant in the common conditions that have been identified.

(1) DISSEMINATION OF LEARNING MODEL.—Dissemination methods shall include but not be limited to the following methods:

(A) Specialized teams deployed by the Initial Participants to teach and facilitate implementation on site.

(B) Distance-learning, taking advantage of latest interactive technologies.

(C) On-line, fully accessible repositories of shared learning and information related to best practices.

(D) Advanced population health information technology models.

(2) EVALUATION OF PARTICIPANTS.—

(A) IN GENERAL.—Evaluation of initial participants shall be based on documented success in meeting quality and efficiency measurements. Specific statistically valid measures of evaluation shall be determined by the Secretary.

(B) PERFORMANCE TARGETS.—The Secretary shall develop performance targets for participants. Performance targets developed under the preceding sentence shall be based on whether participants have improved their performance under section 1886(p) of the Social Security Act, as added by section 3008, section 1886(q) of such Act, as added by section 3025, or any similar program under title XVIII of the Social Security Act (as determined by the Secretary).

(e) MEASUREMENT OF LEARNING MODEL.—Participants shall implement techniques under the comprehensive learning model. The Secretary shall determine whether such implementation improves quality and efficiency, including cost savings relative to baseline spending for the common conditions specified under subsection (c)(5)(B)(iv) and quality measures endorsed by a consensus-based organization or otherwise chosen by the Secretary. The Collaborative shall prepare a report annually on each participant's performance with respect to the efficiency and quality measurements established by the Secretary. Such report shall be submitted to the Secretary and Congress and shall be made publicly available.

(f) ADMINISTRATIVE PAYMENT.—For purposes of carrying out this section, there are authorized to be appropriated $228,000,000, to remain available until expended. Amounts appropriated under the preceding sentence shall be distributed in the following manner:

(1) The Coordinating Organization shall receive $10,000,000 per year for program development related to the Collaborative, including for health information technology and other infrastructure, project evaluations, analysis, and measurement, compliance, auditings and other reporting. Not less than $5,000,000 of such funds shall be provided for education and training, including for support for the establishment of training teams for the Collaborative, to assist in the integration of new health information technology, best practices of care delivery, microsystems of care delivery, and a distributive e-learning network for the Collaborative.

(2) Each Initial Participant shall receive $4,000,000 per year for internal program development for health information technology and other infrastructure, education and training, project evaluations, analysis, and measurement, and compliance, auditing, and other reporting.

(3) Beginning in 2013, the Secretary may provide funding to additional participants in the Collaborative in an amount not to exceed $4,000,000 per participant per year under the same use guidelines as apply to the Initial Participants.

(g) CONTINUATION OR EXPANSION.—

(1) TERMINATION.—Subject to paragraph (2), the Collaborative shall terminate on the date that is 6 years after the date on which the Collaborative is established.

(2) EXPANSION.—The Secretary may continue or expand the Collaborative if the Collaborative is consistently exceeding quality standards and is not increasing spending under the program.

(h) TERMINATION.—The Secretary may terminate an agreement with a participating organization under the Collaborative if such organization consistently failed to meet quality standards in the fourth year or any subsequent year of the Collaborative

(i) REPORTS.—

(1) PERFORMANCE RESULTS REPORTS.—The Secretary shall provide such data as is necessary for the Collaborative to measure the efficacy of the Collaborative and facilitate regular reporting on spending and cost savings results relative to a value-based program initiative.

(2) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and annually thereafter, the Secretary shall submit to Congress and make publicly available a report on the authority granted to the Secretary to carry out the Collaborative under this section. Each report shall address the impact of the use of such authority on expenditures for, access to, and quality of, care under title XVIII of the Social Security Act.

(j) DEFINITIONS.—In this section:

(1) BENEFICIARY.—The term ''beneficiary'' means a Medicare beneficiary enrolled under part B and entitled to benefits under part A who is not enrolled in Medicare Advantage under Part C or a PACE program under section 1894, and meets other criteria as the Secretary determines appropriate.

(2) HIGH VALUE HEALTH CARE.—The term ''high value health care'' means the care delivered by organizations shown by statistically valid methods to meet the highest quality measures established by the Secretary as of or after the date of enactment of this Act and to be delivering low-cost care with high patient satisfaction and clinical outcomes.

(3) LEARNING MODEL.—The term ''learning model'' means a standardized model developed by the Initial Participants in the Collaborative and based on best practices, as jointly developed and put into practice at the Initial Participant's respective institutions.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(k) ADDITIONAL MONITORING.—The Secretary may monitor data on expenditures and quality of services under title XVIII of the Social Security Act with respect to a beneficiary after the beneficiary discontinues receiving services under the Collaborative.

(l) OTHER PROVISIONS.—

(1) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under this section or otherwise of—

(A) the elements, parameters, scope, and duration of the Collaborative, including the selection of participants in the Collaborative;

(B) the establishment of targets, measurement of performance;

(C) determinations with respect to whether savings have been achieved and the amount of savings; and

(D) decisions about the extension or expansion of the Collaborative.

(2) ADMINISTRATION.—Chapter 35 of title 44, 4 United States Code shall not apply to this section.

(3) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of the Collaborative with regard to violations of section 1877 of the Social Security Act (popularly known as the ''Stark law'').

(4) ANTI-DISCRIMINATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the Collaborative, or with an entity to administer the Collaborative, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the Collaborative for beneficiaries to participate in the Collaborative, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS–

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, December 17, 2009, at 2:15 p.m. in room 628 of the Dirksen Senate Office Building to conduct a business meeting on pending committee issues, to be followed by an oversight hearing on the Cobell v. Salazar Settlement Agreement.

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

AUTHORITY FOR COMMITTEES TO MEET–

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 15, 2009, at 2:30 p.m. in room 253 of the Russell Senate Office Building.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate to conduct a hearing on December 15, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on December 15, 2009, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Ensuring the Effective Use of DNA Evidence to Solve Rape Cases Nationwide.''

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 15, 2009, at 2:30 p.m.

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

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs' Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia be authorized to meet during the session of the Senate on December 15, 2009, at 10 a.m. to conduct a hearing entitled ''One DHS, One Mission: Efforts to Improve Management Integration at DHS.''

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

NEAR EASTERN AND SOUTH AND CENTRAL ASIAN AFFAIRS SUBCOMMITTEE

Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 15, 2009, at 10 a.m., to hold a Near Eastern Subcommittee hearing entitled ''Reevaluating U.S. Policy in Central Asia.''

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

PRIVILEGES OF THE FLOOR

Mr. CRAPO. Mr. President, I ask unanimous consent that Rachel Johnson and Amanda Critchfield, two staffers from my office, be granted the privilege of the floor for the remainder of the consideration of H.R. 3590.

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

Mr. MENENDEZ. Mr. President, I ask unanimous consent that Megan Moreau, a fellow in my office, be given floor privileges for the remainder of debate on H.R. 3590, the health care reform legislation currently pending.

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

ORDERS

Mr. PRYOR. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. Wednesday, December 16; 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, with the first hour equally divided and controlled between the leaders or their designees, with the majority leader controlling the first half and the Republicans controlling the second half.

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

PROGRAM

Mr. PRYOR. Mr. President, we expect votes tomorrow in relation to the Hutchison motion to commit regarding taxes and implementation and the Sanders amendment regarding a national single-payer system. Senators will be notified when any votes are scheduled.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. PRYOR. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order.

There being no objection, the Senate, at 7:56 p.m., adjourned until Wednesday, December 16, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED AND FOR APPOINTMENT AS THE JUDGE ADVOCATE GENERAL OF THE AIR FORCE UNDER TITLE 10, U.S.C., SECTION 8037:

To be lieutenant general

BRIG. GEN. RICHARD C. HARDING

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE AIR FORCE UNDER TITLE 10, U.S.C., SECTION 12203(A):

To be colonel

LAWRENCE W. STEINKRAUS, JR.

THE FOLLOWING NAMED INDIVIDUALS FOR APPOINTMENT TO THE GRADE INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531(A):

To be major

KRISTI L. JONES
JAMES A. OBESTER, JR.
PAVEENA POSANG
BRUNO A. SCHMITZ

THE FOLLOWING NAMED INDIVIDUALS FOR APPOINTMENT TO THE GRADES INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531(A):

To be lieutenant colonel

RAYMOND KING

To be major

LISA B. BROWNING
BERNHARD K. STEPKE

IN THE ARMY

THE FOLLOWING NAMED INDIVIDUAL FOR REGULAR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY NURSE CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

DAWN Y. TAYLOR

THE FOLLOWING NAMED INDIVIDUALS FOR REGULAR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL SERVICE CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

WALTER COFFEY
RUSSELL P. REITER

THE FOLLOWING NAMED INDIVIDUALS FOR REGULAR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

DEAN A. AMBROSE
RONALD R. DURBIN
THOMAS R. PRINCE
JOHN W. TROGDON

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

PATRICK R. BOSSETTA
WILLIAM J. COFFIN
DENNIS C. DEELEY
HAMILTON D. RICHARDS
HELEN E. ROGERS
JOHN R. WHITFORD

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS UNDER TITLE 10, U.S.C., SECTION 624:

To be major

WILLIAM J. MITCHELL

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS RESERVE UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

SAM B. CLONTS, JR.
JAMES C. FAILMEZGER
CAROLINE P. FERMIN
HENRY E. MULL, JR.
RALPH L. PRICE III