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House of Representatives

The House was not in session today. Its next meeting will be held on Wednesday, December 23, 2009, at 11:30 a.m.

Senate

SUNDAY, DECEMBER 20, 2009

The Senate met at 1 p.m. and was called to order by the Honorable JEANNE SHAHEEN, a Senator from the State of New Hampshire.

PRAYER

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

Let us pray.

Most merciful God, the fountain of wisdom and goodness, on this snowy weekend, guide our lawmakers with Your insights. When confused thoughts emerge, clarify and straighten them with Your wisdom. Bring their desires and powers into conformity to Your will. May their lives be as lighted windows amid the encircling gloom. Lord, save them from a cynical pessimism by reminding them that these challenging times are in Your Hands. Strengthen their resolve to press on with focused attention on the duties of this day.

Bless also the many unseen workers who support our Senators with sacrificial and faithful labors. Lord, reward them for their diligence and patriotism.

We pray in Your merciful Name. Amen.

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".

Members of the House of Representatives' statements may also be submitted electronically by e-mail, to accompany the signed statement, and formatted according to the instructions for the Extensions of Remarks template at http://clerk.house.gov/forms. The Official Reporters will transmit to GPO the template formatted electronic file only after receipt of, and authentication with, the hard copy, and signed manuscript. Deliver statements to the Official Reporters in Room HT–59.

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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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PLEDGE OF ALLEGIANCE

The Honorable JEANNE SHAHEEN 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 bill clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 20, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JEANNE SHAHEEN, a Senator from the State of New Hampshire, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. SHAHEEN thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Madam President, following leader remarks, the Senate will resume consideration of the health care legislation, with the time until 1:30 p.m. equally divided and controlled between the two leaders or their designees. Beginning at 1:30 p.m., and until 11:30 p.m. tonight, the time will be controlled in alternating hours, with the Republicans controlling the first hour.

At 11:30 p.m., the Senate will recess until 12:01 a.m., with the time until 1 a.m. equally divided and controlled between the leaders or their designees, with the majority leader controlling the final 10 minutes and the Republican leader controlling the 10 minutes prior to that.

At 1 a.m., tomorrow, the Senate will vote on the motion to invoke cloture on the managers' amendment to the health care bill.

Madam President, the time I have until 1:30 p.m., I designate to the majority whip, the senior Senator from Illinois.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The bill 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.

Reid amendment No. 3276 (to amendment No. 2786), of a perfecting nature.

Reid amendment No. 3277 (to amendment No. 3276), to change the enactment date.

Reid amendment No. 3278 (to the language proposed to be stricken by amendment No. 2786), to change the enactment date.

Reid amendment No. 3279 (to amendment No. 3278), to change the enactment date.

Reid motion to commit the bill to the Committee on Finance, with instructions to report back forthwith, with Reid amendment No. 3280, to change the enactment date.

Reid amendment No. 3281 (to the instructions (amendment No. 3280) of the motion to commit), to change the enactment date.

Reid amendment No. 3282 (to amendment No. 3281), to change the enactment date.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 1:30 p.m. shall be equally divided and controlled between the two leaders or their designees.

The Senator from Illinois.

Mr. DURBIN. Madam President, I thank the majority leader for designating that I should control half the time between now and 1:30.

I would like to, first, thank all the people who are here, the staff and the pages. This has been a tough session for many but tougher for many of them than some Members of the Senate because many times they have had to wait until the very last Senator of either political party has finished for the day before they go home. I was reflecting on that yesterday afternoon in the midst of one of the toughest, historic snowstorms in Washington, DC; that hundreds of staff people were waiting at their post, doing their jobs on a Saturday, in the middle of a snowstorm, when virtually every business around Washington was closing down. I wish to thank them and the pages on both sides of the aisle for their patience and commitment to this great country and this great institution.

Why are we here on Sunday? Why were we here on Saturday? Why are we going to take a vote at 1 in the morning on Monday? Good questions, and I am not sure there are satisfying answers. But there are answers. We are here because we are trying to finish health care reform. It has been a project that has been underway for almost a year now, since the President challenged us to do something, and a lot of effort has been expended on both sides of the aisle. But I will say I can speak for our side of the aisle.

Senator MAX BAUCUS came to me more than a year ago and sat down in my office to talk about health care reform. He was preparing for this battle as chairman of the Senate Finance Committee and knew he would play a central role, gathering the opinions of members of his committee and Members of the Senate.

Efforts were underway with Senator Kennedy from his remote location in Massachusetts, recuperating from surgery and from cancer therapy, trying to keep his committee on track toward health care reform. He turned over that mantle to Senator CHRISTOPHER DODD of Connecticut, who did an admirable job with the Senate Health, Education, Labor, and Pensions Committee.

They prepared for and had hearings. They entertained hundreds of amendments. In fact, I believe there were over 160 amendments that were proposed by the Republicans, and many of them were adopted in the HELP Committee.

Senator COBURN of Oklahoma filed 212 amendments during the HELP Committee markup. He offered 38 amendments to the bill. Nineteen of his amendments—half of them—were agreed to. Of those that were offered, 15 were not agreed to—all by rollcall vote. So 13 amendments offered by the Senator from Oklahoma were included in the bill that is before us today.

He has questioned whether the current procedure gives him an opportunity to offer amendments. The fact is, we are now on our 21st day of considering health care reform. Exactly 4 amendments have been offered by the Republican side of the aisle, 4 substantive amendments to change provisions in this bill of 2,000 pages—in 21 days, 4 amendments. They offered six motions to stop the debate, send the bill back to committee. They were generic motions. They did not ask for specific changes. They just take on an issue in the bill and say: Send it back to the committee and tell them to solve this problem and then bring it back to the floor at a later time. Well, that is kind of a procedural and, if I might say, political statement more than a substantive statement about a provision in the bill.

So exactly four amendments have been offered by the Republican side of the aisle that deal with substance. Some of their efforts have been in protection of the health insurance industry, particularly a program called Medicare Advantage, which was created by private health insurance companies to prove to government they could provide Medicare more cheaply.

Some did but most did not, and now we are paying up to $17 billion a year subsidizing private health insurance companies that told us at the start: We will save you money. It turns out they are costing us money—a lot of money—and many of us think it is wasteful. We would rather have that money spent on basic Medicare, making certain there is solvency in Medicare and a good, strong future.

So when you look at the state of the situation, we are now on a cloture motion to bring a close to the debate on health care reform, after almost 3

weeks and four Republican amendments—only four were offered. There never was a Republican substitute, no Republican proposal for health care reform. We have been told this might exist. We have never seen it. Of the four amendments they offered, not one was this substitute that was going to deal with the health care system. It is a promise that has not been kept. They kept saying: It is coming. Pretty soon we are just going to put this thing right in the RECORD. Well, it never happened. In 3 weeks, it never happened.

It is hard work to prepare a substitute. The reason this took so long and has dragged on for so long is we had to take every page of this and turn it over to the Congressional Budget Office. They sit there with their economists, pore over it and say: Well, is it going to add to the deficit or reduce the deficit? Is it going to reduce health care costs? What is the impact? It takes them some time to do that. The Republicans know if they are going to have a substitute, it will have to go through the same rigorous appraisal, and they have not done that, I think because it is hard. In fact, from their political point of view, it might be impossible to try to solve the problems facing health care in America without taking the path we have taken.

What does this bill do? The basics are obvious. First,—and this is all backed up by the Congressional Budget Office—it will reduce the cost of health care. It will make it more affordable. A health care policy for a family of four offered by an employer, on average, cost $6,000 10 years ago. Today, it costs $12,000 a year. It has doubled in 10 years, and in 8 years it will double again to $24,000. We have to slow this down or it will reach a point where more and more people will be uninsured, fewer businesses will offer health insurance, and more individuals will find themselves unable to afford the basic protections they need for themselves and their families.

So the Congressional Budget Office tells us we reduce the growth in the cost of health care, and that is a good thing. They came through with a dramatic revelation yesterday when they said this bill will reduce our deficit as well. If the cost of health care goes down, the cost of health care programs offered by government goes down. They tell us in 10 years we will save $130 billion from the deficit. That is a dramatic savings—the largest in history. But then the news got better. They said, in the second 10 years, instead of saving $650 billion from our debt and deficit, it could reach double that amount: $1.3 trillion in savings in the second 10 years.

I would say to those who give speeches day after day about our deficit, I invite you—in fact, I challenge you to come up with a bill that does this, that gives us actual savings of $130 billion in 10 years and $1.3 trillion in the next 10 years. It is hard to do. It may be impossible for some to come up with such a bill.

This bill also will extend the coverage of health insurance so 94 percent of Americans will have coverage. Madam President, 30 million Americans today who have no health insurance will have health insurance under this bill. Half of them are poor enough that they will receive Medicaid; the other half will qualify for the insurance exchanges and other tax credits to help them pay their premiums so they can have and afford health insurance.

Ninety-four percent of Americans—we have never, ever achieved a level of insured Americans that reached that number. Thirty million Americans will be receiving health insurance at the end of the day.

This bill will start giving consumers across America protections they need against abuses from health insurance companies. One of the things near and dear to my heart about this amendment, which has been criticized by some, is this amendment, which was offered yesterday, has been on the Internet, for those who are interested to read it, for 24 hours, and will continue to be available.

This amendment says that as soon as this is signed, health insurance companies across America cannot deny coverage to children, those under the age of 18, because of a preexisting condition. That means if your son or daughter is diagnosed with diabetes, juvenile diabetes, and you find it difficult to get health insurance today because of that preexisting condition, they will no longer be able to discriminate against your child and your family because of this bill. That is one thing. There are many others.

This whole notion of health insurance companies waiting until you get sick and cut you off when you need them the most, that comes to an end, under this amendment, in 6 months. So over and over again, we give consumers across America a chance to have the coverage they paid for when they need it the most. We used to call it the Patients' Bill of Rights, and it used to be bipartisan. It was Senator Kennedy and Senator MCCAIN who brought it to us, and it failed because the health insurance companies were so politically powerful. But we have got them this time. If we can pass this bill, we finally have the protections the American people so desperately need.

There are other provisions in the bill. Right from the beginning, we provide more help to small businesses. These are businesses with 50, 25 employees and an average payroll of $50,000 an employee to $25,000 an employee or less. For each of those businesses, we say: We are going to help you buy health insurance for the owners of the business as well as for the employees. Those are the folks who are struggling and losing coverage, people such as the realtors in your hometown. Did you know one out of four realtors in America has no health insurance. I did not know it until they came to see me. Well, this gives them a hand. It gives them a tax break as a small business to provide health insurance for their people.

I am going to reserve the remainder of my time. I will tell you, we are here today. We are burning the hours off the clock to vote at 1 a.m. in the morning. It would be more humane to the people who work here, to the Members of the Senate and their families, for us to reach a gentlemanly and gentlewomanly agreement that we will have this vote at a more reasonable time. If we have the 60 votes, which I think we have the commitments for, then we can decide how to move forward.

We have had a long, arduous, and sometimes taxing debate leading to this moment. I think it is time for a vote. The sooner we can reach that vote, the sooner the American people will know that we will either succeed or fail in bringing stability and security when it comes to their health insurance, making that health insurance more affordable, extending the reach and protection of health insurance to record levels of Americans, making sure we have health insurance reform as part of this, and at the same time, at the very same time reducing our deficit.

I reserve the remainder of our time.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. DURBIN. Madam President, how much time do I have remaining?

The ACTING PRESIDENT pro tempore. There is 1 minute 50 seconds.

Mr. DURBIN. Madam President, I wish to suggest the absence of a quorum and ask unanimous consent that the time under the quorum be allotted equally to both sides.

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

The clerk will call the roll.

The assistant bill clerk (Sara Schwartzman) proceeded to call the roll.

Mr. CHAMBLISS. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mr. CHAMBLISS. Is it correct, Madam President, the minority side has the hour from 1:30 to 2:30?

The ACTING PRESIDENT pro tempore. That is correct. Under the previous order, the time until 11:30 p.m. shall be controlled in alternative 1-hour blocks with the Republicans controlling the first hour.

Mr. CHAMBLISS. I, then, Madam President, ask unanimous consent Senators CORNYN, GRAHAM, ISAKSON, and myself be allowed to have a colloquy during this first hour, from 1:30 to 2:30.

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

Mr. CHAMBLISS. Madam President, here we are on our 21st legislative day, less than 4 weeks, on the most major piece of health care legislation ever

proposed in the history of our great country. That is less than weeks that we have been on this bill that seeks to change the way health care is delivered in America and also seeks to change the way individuals have access both to health care itself as well as to insurance. During this period of time—and we are headed, I might say, too, toward passage of this bill in the Senate over the next couple of days.

I do not remember, in my 15 years in the Congress, both in the House and in the Senate, any major piece of legislation such as this being debated and ultimately brought to a final vote within such a short period of time. I have been involved in farm bills that have been on the Senate floor for longer than this—any number of other pieces of legislation that we deal with on a regular basis that have been on the Senate floor for longer than that period of time.

I heard the assistant majority leader a little earlier talking about the fact that we have had the opportunity to amend this bill. The fact is, the Republicans have been offered the opportunity to introduce 10 amendments to this massive piece of legislation for debate on the floor. We have a number of other amendments that have been filed. The four of us here today have significant amendments that we filed that now we are not going to have the opportunity to call up. It is extremely unusual for such a massive change in American policy being debated and voted upon without not only bipartisan support but without bipartisan participation from the standpoint of giving us the opportunity to file amendments, to have those amendments debated and voted upon.

The assistant majority leader also referenced amendments by Senator COBURN. I am not going to speak for him. He will be on the floor of the Senate later today to certainly speak well for himself. But the fact is, he and other Members of the HELP Committee offered any number of amendments, as well as Members of the Finance Committee offered any number of amendments, that were voted down in the HELP Committee and in the Finance Committee on a pure partisan vote.

It was the opportunity for meaningful participation by Republicans, who have some pretty good ideas about health care, to participate in the development of this bill, and it simply did not happen.

Let me say what Republicans are for. There have been comments on this floor that there has been no substitute bill offered. The fact is, Senator BURR and Senator COBURN, who will be on the floor a little bit later, have spent hours on the floor of this Senate talking about their proposed bill that is not going to see the light of day. It has never been allowed to come up in committee, and it is not going to be allowed to come up on the floor of the Senate because the majority leader has done what we call fill the tree. That is the Washington speak way of saying that all amendments are now cut off. There will be no more additional amendments debated and brought up for a vote. But that is just one of four separate plans that have been filed and laid on the table, not just for the last 72 hours but for the last several months. They have been available to look at online. There are any number of cosponsors to the bipartisan Wyden-Bennett bill. There is also the Gregg bill. There is the Coburn-Burr bill. There are any number of alternate proposals out there that the majority has simply decided: We do not think those bills are worth even debating on the Senate floor, so they have not allowed those bills to come up.

But what are Republicans for? We have said this over and over. Let me just say, No. 1, we are for meaningful, affordable access to health insurance by every single American. We can do it in a way that does not raise taxes. We are for providing coverage for all Americans, including those who have had preexisting conditions. We can do it in a way that does not raise taxes.

We are for trending down the cost curve; when it comes to health care reform, if we do not turn that cost curve downward, then we have failed the American people. Frankly, the independent Congressional Budget Office has said health care cost under the Reid proposal is going to not only continue to go up but it is likely—not only will it continue on its current curve, but it is going to go up and not down.

The way you can ensure that cost curve turns down, just two Republican proposals that we think have an awful lot of merit but are not going to be considered and certainly are not going to be included—are not included in the managers' amendment that has now been filed—one of those is tort reform. Physicians all across the country have been crying for this for years. But, more so, health agencies and individuals who have to pay health care bills have been crying for this for years. We can do it in a way that will allow every aggrieved individual who is injured as a result of negligent health care being delivered to have their day in court. Yet we need to provide some means of the elimination of the frivolous lawsuits that go so much toward physicians having to call for tests that they might not otherwise need; and also to prevent the spiraling costs, on the delivery side, of health care because of the high cost of malpractice insurance as well as other measures.

The other way we can trend that curve down is to provide preventive incentives to individuals across America to live healthier lives. There is example after example that we have talked about on the floor of the Senate—from health care providers, employers who have provided incentives in their program, their health insurance program, that have in fact lowered costs. We can do that. There are proposals to do that, but they are not included in the managers' package.

Insurance reform—Republicans have been very strong about the fact that, as a part of overall health care reform, we need to reform the insurance industry, rein in some measures that have caused the cost of health insurance that is provided by employers to, again, not only level off but ultimately trend downward.

How do we do that, and what ideas have been proposed? We have proposed the sale of insurance policies across State lines. There is a provision in the underlying bill that does that. I am very pleased to see that included.

Another thing we can do is to allow for what is called associated health plans that Republicans have been promoting for years. Every time it has come up for a vote in this body, the Democrats have opposed allowing individuals across State lines to group together and spread the risk of health insurance coverage. It would go a long way toward reducing the cost of health insurance premiums. But, unfortunately, we have not been allowed to move forward with that proposal.

Let me mention a couple of things, before I turn to my friend from Texas, with respect to the changes in the Reid amendment that was filed yesterday. Again, there have been a number of individuals who have come to the floor since that amendment was filed yesterday to talk about the fact that it is online, and as we look through it more and more we are finding more and more about it, that is true. But it certainly does not meet the test of giving us 72 hours before we vote on it.

The number of pages in the bill now, the base bill plus the Reid amendment plus the Indian health bill, which is now included by reference, totals 2,733 pages. The gross Medicare cuts—and these are not slowing the growth of Medicare. These are direct Medicare cuts that are being used to finance the underlying health care bill—now totaling $470.70 billion. The gross tax increases in the Reid amendment now total $518.5 billion. CBO says the gross cost of the insurance coverage expansion is $23 billion higher under the Reid amendment than it was under the base bill. Federal revenues or Federal taxes increase by almost $26 billion under the managers' package.

All told, the amendment reduces the deficit by $2 billion—going from $130 to $132 billion. But, boy, is that ever a figleaf. We are going to talk about the CLASS Act that provides for that increase in the deficit.

The Federal cost curve, according to CBO, still goes up. I alluded to that a little bit earlier.

There is a slight increase in additional coverage—but still under the Reid amendment there will be 23 million Americans left uninsured. That is not what we have heard from the other side of the aisle from day one about making sure that every single American was covered.

Despite the fact the Democrats have said changes in the managers' package would improve the delivery system, CBO also says it is likely that the amendment would have little impact on premiums.

As we move toward the cloture votes on this bill over the next couple of days, I think it is important for the American people to get some understanding of the fact that the deals that have been made, the deals that have been cut to get the Democrats to 60 votes on this bill do not do what has been said over and over by folks on the other side of the aisle.

I would now like to ask my friend from Texas how it impacts Texas, the managers' amendment, as well as the underlying bill and other comments he has relative to the bill.

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

Mr. CORNYN. Madam President, I look forward to engaging with both the Senator from Georgia and the Senator from South Carolina, Mr. GRAHAM. I have been in the Senate now for 7 years, which is not all that long compared to the length of service of a number of Senators. I was and have been proud to represent the 24 million citizens of the State of Texas here in the Senate and the seat that was first held by Sam Houston in 1846.

Sometimes the Senate is referred to as the world's greatest deliberative body. I think that description is a description that inspires schoolchildren and lovers of this great democracy of ours to admire and respect this body. But I have to tell you, I think the world's greatest deliberative body might not apply to this particular piece of legislation. It might, rather, be called the world's biggest railroad because of the railroading of the legislation that was revealed here only yesterday by Senator REID, cooked up behind closed doors with a variety of interest groups negotiating deals on the side, deals that are unknown.

We know some of those pertain to hospitals, some to the pharmaceutical companies. Then I heard one of our other Senators from North Carolina yesterday say we should call this ''The Price Is Right'' because we know a number of Senators held out for various inducements, financial inducements, to encourage them to get to the 60 votes.

So we do not know what kind of deals have been cut behind closed doors, what kind of deals individual Senators may have made. But the American people need to know what is in this legislation and how it will affect them.

Unfortunately, notwithstanding the fact that the President of the United States said, You know what, when I am elected President, we are going to have negotiations around a big table and televise it on C–SPAN, good luck. So much for that broken promise.

We know other Senators who expressed the same concerns the Senator from Georgia did about having at least 72 hours by posting this on the Internet so the American people can read it and so we can consult with our constituents—the hospitals, the small businesses, the doctors—to say how does this affect you?

We had eight Democratic Senators on October 6, 2009, who said they wanted the CBO scores and they wanted them posted 72 hours ahead of time before the first vote. So much for that. We know that is going to be thrown out the door as well.

That demand, I suppose, was made more for public relations rather than any real desire to find out what is in the bill and share it with the American people because we know legislative language will be available only 40 hours before the first vote at 1 a.m. this morning, literally in the middle of the night. The Congressional Budget Office score is available only 37 hours before the first vote.

What we are talking about is this legislation. The Senator from Georgia said 2,700 pages, I believe, when you consider all of the legislation we are going to be asked to vote on the first time on a cloture vote at 1 in the morning, about 12 hours from now. We have been feverishly reviewing this language to find out what is in it. Frankly, what we find out is that it makes things worse rather than better in a number of key respects.

For example, we know that America spends near double what any other industrialized Nation does on health care. One of the stated goals, one which the Democrats and Republicans both agree on, is that this reform ought to control those costs rather than make it worse. I have an amendment, amendment No. 2806, designed to ensure that health care reform achieves the goal we all support.

We know that private insurance premiums have more than doubled in the last 10 years for American families. The Congressional Budget Office estimates that taxpayer spending on government health programs will rise to 12 percent of our economy by 2050. That will be a debt of $322,000 for the unfunded liabilities of Medicare alone. This bill does not make things better. It makes things worse, according to the Obama administration Chief Actuary.

I have an amendment which would apply the truth test to the Obama administration's own independent Actuary, based on the evidence the Reid bill would increase health care costs for the Nation, for American families, for American taxpayers. This amendment leaves it up to the Office of the Actuary of the Centers for Medicare and Medicaid Services. If that office finds the Reid bill does lower health costs as advertised, the bill would then proceed to go into effect. But if, in fact, it does not, then it will not.

Advocates of the Reid health bill continue to promise it lowers health care costs, but this amendment will apply the truth test to the Obama administration's own independent Actuary.

I see the distinguished majority whip on the floor. I am glad he is here because he may have something to say about this.

I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up amendment No. 2806.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. DURBIN. Reserving the right to object.

The ACTING PRESIDENT pro tempore. The Senator from Illinois.

Mr. DURBIN. Madam President, this is the 21st day of debate. There have been four substantive amendments offered by the Republican side. They have had ample opportunity to call for this——

Mr. CORNYN. I call for the regular order.

The ACTING PRESIDENT pro tempore. Regular order has been called for. Does the Senator object?

Mr. DURBIN. I object.

The ACTING PRESIDENT pro tempore. Objection has been heard.

Mr. CORNYN. Madam President, I ask my colleagues to comment on some of the other broken promises. The President made a solemn pledge that he would sign a universal health care bill. This bill, as I understand it, still leaves 15 million people without insurance coverage. He says the costs will be cut by up to $2,500 a year. The reality is the average premiums would increase by $2,100.

I ask perhaps our distinguished colleagues from South Carolina and Georgia to comment on the promises that the President has made with regard to transparency, the promises he has made with regard to premiums going down rather than up, the promises he has made with regard to Medicare—promises it appears this bill will not allow him to keep.

Mr. GRAHAM. Everything the 2008 campaign was about has basically been discredited and discarded in this whole health care debate. I thought it was change we could believe in. I thought there was going to be a new way of doing business in Washington, and God knows there needs to be. I thought we were going to negotiate the health care bill on C–SPAN and everybody would have a seat at the table, including the drug companies. I thought we were going to allow reimportation of prescription drugs to allow American consumers to purchase drugs dramatically cheaper.

Not only have we not had any negotiations on C–SPAN, you couldn't find the room where the negotiations were going on. The old way of doing business looks good compared to this process. There was a negotiation going on on the biggest proposal we will probably ever vote on, one-sixth of the economy, between two people: the Senate majority leader and the Senator from Nebraska.

The second in command on the Democratic side told Senator MCCAIN: I am just as in the dark as you are. We have gone to a promise of being on C–SPAN to everybody was in the dark. I don't know how that plays. I hope it plays poorly because at the end of the day, what we are doing here is absolutely unconscionable. When you thought it couldn't get any worse in Washington, when you thought your government had reached a low point, well, it has gotten worse. I will be talking about the 60th vote here soon, how they got that 60th vote. And if that is OK with the American people, which I do not believe it will be, if that is OK with our body, then our best days are behind us as a country.

Mr. CORNYN. May I ask the Senator from South Carolina about this other promise? Does he recall the President saying in July of 2009, if you like what you have, you can keep it? Is the Senator aware of the fact that according to the Congressional Budget Office, between 8 and 9 million people who would have been covered by employment-based plans under the current law would not have an offer of such coverage under this bill if passed, and seniors, because of the cuts to Medicare, particularly Medicare Advantage, will actually have their benefits cut? How do you reconcile those promises with what we see in this monstrosity of a bill?

Mr. GRAHAM. They cannot be reconciled. I hope American seniors are paying attention. We are going to take $470 billion out of Medicare in the next decade and use that money to create new government programs. If you are senior citizens out there, the doctors and hospitals you go to—and it is hard to find Medicare doctors right now; a lot of doctors are reluctant to take Medicare patients because the reimbursement rates are so low. Rural hospitals are on their knees because the Medicare rates are so low. Take $470 billion out of the system and see what happens to the provider community.

What does it mean to seniors? It means your chance of finding the doctor or hospital to take care of you as a Medicare patient is going down, not up. What does it mean to Medicare? It is due to go bankrupt by 2017. By taking money out of the system, not reforming Medicare, but using it as another purpose has accelerated the problems of Medicare. Not only has that promise been broken, we have done something no other Congress has ever done to Medicare—take money out of it and give it to somebody else. That is not right. We were within inches of expanding Medicare to people from 55 to 64 which would put the system at risk.

My point is simply this. We started this debate as a way to reform health care, and a lot of us agree on many things. It wound up being what does the Democratic Party need to do to pass a bill. Nobody cares what is in this bill anymore. All the objections about the CLASS Act and about fiscal responsibility and about the public options being in or out have given way to get this thing done before Christmas.

This is not about health care reform. It is about one political party feeling as though they have to pass a bill no matter what is in it. And that is sad.

Mr. CORNYN. I wonder if my colleagues will comment. I have one last chart I want to share with them and anybody who might be watching on this Sunday afternoon shortly before Christmas.

Every public opinion poll I have seen says the American people do not want us to pass this bill. So one has to wonder: All of us have to run for election in our States. Obviously, to win an election, you have to get a majority of voters. But 56 percent of U.S. voters in the country say they do not want this bill to pass. And yet this thing seems as though it is on an unstoppable path toward passage because 60 Senators, apparently defying the will of their constituents, seem determined to pass the bill.

Can my colleagues explain to me what they think is going on here?

Mr. CHAMBLISS. I think it is obvious it is pure arrogance on the part of the folks on the other side of the aisle. The American people do not want it, but they are saying Washington knows better than the people back home know. That is pretty clear.

I know my colleague from Georgia is like me, when we go back home, we get stopped in the airport, in the grocery store, on the streets, all around different parts of Georgia. People are not happy about what is going on up here with respect to this bill. I wish to ask him about his comments with respect to where we are.

Mr. ISAKSON. Like the Senators from Texas and South Carolina and my senior Senator from Georgia, we all represent the people who vote for us. And in reference to Senator CORNYN's question about popularity, about the way people feel about this legislation, I ask unanimous consent to have printed in the RECORD two letters—one from the Medical Association of Georgia and one from a consolidated group of medical associations representing 92,000 physicians.

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

MAG IN GROUP REPRESENTING 92,000 DOCTORS OPPOSING SENATE HEALTH BILL

ATLANTA.—The Medical Association of Georgia (MAG) is part of a group of state and national specialty medical societies that represents more than 92,000 practicing physicians from across the U.S. that sent a letter to U.S. Senators today urging them to oppose the ''Patient Protection and Affordable Care Act'' (H.R. 3590) because it clears the way for government-controlled medical care.

MAG President Gary C. Richter, M.D., says, ''We believe that this bill would create a staggering volume of new federal regulatory requirements for medicine, that it isn't sustainable from a budget standpoint, that a 'public' or 'community' heath insurance option may lead to a single-payer system, that the measure lacks meaningful tort reform and actually discourages proven reforms like limiting attorney fees and malpractice caps, and that the bill does not fix the Medicare Sustainable Growth Rate, or SGR, formula.''

In the letter, the physician groups ask Senate leaders to ''draft a more targeted bill that will reform the country's flawed system for financing health care, while preserving the best health care in the world.'' The letter states, ''We are therefore united in our resolve to achieve health system reform that empowers patients and preserves the practice of medicine—without creating a huge government bureaucracy.''

The letter also highlights some of the bill's more ''problematic provisions,'' stressing that it undermines the patient-physician relationship. The correspondence points out that the bill does not provide for the right to privately contract—a ''touchstone of American freedom and liberty''—and it stresses that ''patients should have the right to choose their doctor and enter into agreements for fees and services without penalty.'' The letter urges lawmakers to develop legislation that ''allows patients and physicians to take a more direct role in their health care decisions,'' and it points out that decisions surrounding medical care isn't an appropriate role for the government or other third party payers.

Along with MAG, signatories include the Medical Association of the State of Alabama, the Medical Society of Delaware, the Medical Society of the District of Columbia, the Florida Medical Association, the Kansas Medical Society, the Louisiana State Medical Society, the Missouri State Medical Association, the Nebraska Medical Association, the Medical Society of New Jersey, the Medical Society of South Carolina, the American Academy of Cosmetic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery, the American Association of Neurological Surgeons, the American Society of Breast Surgeons, the American Society of General Surgeons, and the Congress of Neurological Surgeons. Three past presidents of the American Medical Association—Donald J. Palmisano, M.D., William G. Plested III, M.D., and Daniel H. Johnson Jr., M.D.—also signed the letter.

DECEMBER 7, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR SENATOR REID: The undersigned state and national specialty medical societies are writing you on behalf of more than 92,000 physicians in opposition to passage of the ''Patient Protection and Affordable Care Act'' (H.R. 3590) and to urge you to draft a more targeted bill that will reform the country's flawed system for financing healthcare, while preserving the best healthcare in the world. While continuance of the status quo is not acceptable, the shifting to the federal government of so much control over medical decisions is not justified. We are therefore united in our resolve to achieve health system reform that empowers patients and preserves the practice of medicine—without creating a huge government bureaucracy.

H.R. 3590 creates a number of problematic provisions, including:

The bill undermines the patient-physician relationship and empowers the federal government with even greater authority. Under the bill, (1) employers would be required to provide health insurance or face financial penalties; (2) health insurance packages with government prescribed benefits will be mandatory; (3) doctors would be forced to participate in the flawed Physician Quality Reporting Initiative (PQRI) or face penalties for

nonparticipation; and (4) physicians would have to comply with extensive new reporting requirements related to quality improvement, case management, care coordination, chronic disease management, and use of health information technology.

The bill is unsustainable from a financial standpoint. It significantly expands Medicaid eligibility, shifting healthcare costs to physicians who are paid below the cost of delivering care and to the states that are already operating under severe budget constraints. It also postpones the start of subsidies for the uninsured long after the government levies new user fees and new taxes to cover expanded coverage and benefits. This ''back-loading'' of new spending makes the long-term costs appear deceptively low.

The government run community health insurance option eventually will lead to a single-payer, government run healthcare system. Despite the state opt-out provision, the community health insurance option contains the same liabilities (i.e. government-run healthcare) as the public option that was passed by the House of Representatives. Such a system will ultimately limit patient choice and put the government between the doctor and the patient, interfering with patient care decisions.

Largely unchecked by Congress or the courts, the federal government would have unprecedented authority to change the Medicare program through the new Independent Medicare Advisory Board and the new Center for Medicare & Medicaid Innovation. Specifically, these entities could arbitrarily reduce payments to physicians for valuable, lifesaving care for elderly patients, reducing treatment options in a dramatic way.

The bill is devoid of real medical liability reform measures that reduce costs in proven demonstrable ways. Instead, it contains a ''Sense of the Senate'' encouraging states to develop and test alternatives to the current civil litigation system as a way of addressing the medical liability problem. Given the fact that costs remain a significant concern, Congress should enact reasonable measures to reduce costs. The Congressional Budget Office (CBO) recently confirmed that enacting a comprehensive set of tort reforms will save the federal government $54 billion over 10 years. These savings could help offset increased health insurance premiums (which, according to the CBO, are expected to increase under the bill) or other costs of the bill.

The temporary one-year SGR ''patch'' to replace the 21.2 percent payment cut in 2010 with a 0.5 percent payment increase fails to address the serious underlying problems with the current Medicare physician payment system and compounds the accumulated SGR debt, causing payment cuts of nearly 25 percent in 2011. The CBO has confirmed that a significant reduction in physicians' Medicare payments will reduce beneficiaries' access to services.

The excise tax on elective cosmetic medical procedures in the bill will not produce the revenue projected. Experience at the state level has demonstrated that this is a failed policy. In addition, this provision is arbitrary, difficult to administer, unfairly puts the physician in the role of tax collector, and raises serious patient confidentiality issues. Physicians strongly oppose the use of provider taxes or fees of any kind to fund healthcare programs or to finance health system reform.

Our concerns about this legislation also extend to what is not in the bill. The right to privately contract is a touchstone of American freedom and liberty. Patients should have the right to choose their doctor and enter into agreements for the fees for those services without penalty. Current Medicare patients are denied that right. By guaranteeing all patients the right to privately contract with their physicians, without penalty, patients will have greater access to physicians and the government will have budget certainty. Nothing in the Patient Protection and Affordable Care Act addresses these fundamental tenets, which we believe are essential components of real health system reform.

Senator Reid, we are at a critical moment in history. America's physicians deliver the best medical care in the world, yet the systems that have been developed to finance the delivery of that care to patients have failed. With congressional action upon us, we are at a crossroads. One path accepts as ''necessary'' a substantial increase in federal government control over how medical care is delivered and financed. We believe the better path is one that allows patients and physicians to take a more direct role in their healthcare decisions. By encouraging patients to own their health insurance policies and by allowing them to freely exercise their right to privately contract with the physician of their choice, healthcare decisions will be made by patients and physicians and not by the government or other third party payers.

We urge you to slow down, take a step back, and change the direction of current reform efforts so we get it right for our patients and our profession. We have a prescription for reform that will work for all Americans, and we are happy to share these solutions with you to improve our nation's healthcare system.

Thank you for considering our views.

Sincerely,

Medical Association of the State of Alabama; Medical Society of Delaware; Medical Society of the District of Columbia; Florida Medical Association; Medical Association of Georgia; Kansas Medical Society; Louisiana State Medical Society; Missouri State Medical Association; Nebraska Medical Association Medical Society of New Jersey; South Carolina Medical Association; American Academy of Cosmetic Surgery; American Academy of Facial Plastic and Reconstructive Surgery; American Association of Neurological Surgeons; American Society of Breast Surgeons; American Society of General Surgeons; Congress of Neurological Surgeons.

Past Presidents of the American Medical Association: Daniel H. Johnson, Jr., MD, AMA President 1996–1997; Donald J. Palmisano, MD, JD, FACS, AMA President 2003–2004; William G. Plested III, MD, FACS, AMA President 2006–2007.

Mr. ISAKSON. I want to tell my colleagues what these letters say. The first one is to me from Gary Richter, the president of the Medical Association of Georgia. He writes in great detail about the difficulties and problems they have with this legislation, beginning with the stonewall against tort reform by only putting in a demonstration project.

The Senator from Texas is aware of what tort reform can do because his State has made a great improvement in medical malpractice costs because of tort reform, and we in Georgia have tried to experience the same type of thing.

There are many other reasons in here as well. The interesting thing about the letter from the 92,000 physicians represented by their medical associations is they talk not only about what is in the bill but what is not in the bill. I want to read, if I may, one paragraph to demonstrate that point:

Our concerns about this legislation also extend to what is not in the bill. The right to privately contract is a touchstone of American freedom and liberty. Patients should have the right to choose their doctor and enter into agreements for the fees for those services without penalty. Current Medicare patients are denied that right. By guaranteeing all patients the right to privately contract with their physicians, without penalty, patients will have greater access to physicians and the government will have budget certainty. Nothing in the Patient Protection and Affordable Care Act addresses these fundamental tenets, which we believe are essential components of real health system reform.

That is a pretty strong statement from 92,000 American physicians about this particular piece of legislation.

To follow up on the point made by the distinguished Senator from South Carolina, I have a vested interest. I just got my Medicare card. December 1 I became Medicare eligible. When you talk about cutting $470 billion, it gets personal. It gets personal with all those other seniors.

Think about this. Seniors in America have paid their entire lives, at least since 1966 when it was created, They have paid a tax and their employers have paid a payroll tax to go into a trust fund to pay for their health care after they are 65 years old.

We are now basically saying, I say to the Senator from South Carolina, we are taking $470 billion of the tax money you have paid over years of work and we are going to put it in a plan to pay for somebody else's health care. That is basically what it does, and that is patently wrong.

One other thing I want to mention that is critical to me. We are all professionals at what we do. We all argue from our point of view. I understand that and respect that. But something was said earlier today which draws me to have a flashback to make the point about how much we tried on this side to contribute to improvements in health care and better access for all.

The very distinguished majority whip said he talked with realtors and that three in four realtors were uninsured and this would help. The reason they are uninsured is they are not able to form risk groups together associated and affiliated as a like practice. Because of the IRS Code, which this does not amend, a company's employer, who has independent contractors working for them, cannot by law provide them with medical insurance.

In 2006 on the floor of the Senate, 57 Republicans and Democrats offered and voted for the associated health care bill or the small business access to health reform—57 out of 100. We needed 60 like this bill needs to get to cloture. That bill would have allowed associated professions to join together, compete for insurance nationwide, form

risk pools that are large enough to mediate and ameliorate high rates and have a more competitive rate.

He was correct in his statement that three in four do not have health insurance. I was in that business. I know. The reason they do not is because they have to buy on the spot market because they cannot have a group plan. When they buy on the spot market, we are talking about $1,500, $1,800, $2,000 a month, which is unaffordable and unsustainable. But this bill does nothing to address that situation which is one of the largest holes in the uninsured problem.

In fact, when you see the estimates, those who are still left uninsured, a great many of them are going to end up being just those kinds of people—independent contractors that the tax laws prohibit from associating and affiliating with others. And I was proud to be part of that 57, along with the other three distinguished Senators on the floor and a number of Democrats.

There have been lots of efforts made by people on both sides to get us better access and affordable health care. But, unfortunately, they have been blocked all over this philosophic argument of whether health care is going to be government provided or competitive in the private sector. Unfortunately, the ship of state is moving toward the government provision with this legislation, which is one of the reasons I oppose it.

I turn it back to the distinguished senior Senator from Georgia.

Mr. CHAMBLISS. I rise to pose a question to the Senator, and I would ask my colleagues to comment with respect to their States.

The Senator served in the State legislature for many years, and is very familiar with our SCHIP program, which is called PeachCare, and he is also familiar with the rising Medicaid costs that we have seen in our State. What this bill does, in seeking to reach out, as I understand, is to expand the eligibility for Medicaid. We are all for Medicare, but this raises the eligibility level for Medicaid from 100 percent of the poverty level to 150 percent of the poverty level. That will have a huge impact on every single State that is now going through very difficult financial times.

We in Georgia have had a $3 billion shortfall this past year that had to be plugged. I saw the other day in the press where we have almost another $2 billion our legislature is going to have to deal with next month in reducing services around our State. Every State is having that same experience. Yet what this bill does is to put a mandate on States to increase the amount of money that States put into Medicaid. I know the Senator is very familiar with that, and I would ask him to comment.

Mr. ISAKSON. I appreciate the Senator bringing it up. It is what is known in the trade as an unfunded mandate, but I will put some meat on that bone.

This year the State of Georgia had a budget of about $17 billion, and the Medicaid portion—just the Medicaid portion in Georgia—was over $2 billion. So it is approaching, or getting close to, 16, 17, or 18 percent of the entire budget. If this bill passes raising the eligibility from 100 percent to 150 percent, then in 2017—which is the trigger date on this Medicaid provision—Georgia would go from $2.15 billion to over $3¼ billion in its share of Medicaid, and this at a time of declining revenues and greater pressure. That is a recipe for disaster.

Our State, like 43 other States in the United States, can't borrow money. We have to have a balanced budget. If the Federal Government mandates that we spend $3 billion, we have to cut it out of someplace else in our State, such as education or our prisons or the park system or somewhere else.

But it is ironic that Senator CHAMBLISS asked me that question because this morning, as I was preparing to come over, I had the television on, and Arnold Schwarzenegger, Governor of California, was being interviewed. He endorsed this provision originally, but he raised the question that the provisions in this amendment will raise by $3 billion the cost of Medicaid, just in the State of California—a State that had a $60 billion shortfall last year, and next year, he estimates, will have a $20 billion shortfall. If we continue in Washington to mandate funding and don't put our money behind it, we are pushing our States to the brink of bankruptcy, where a number of them already are. It is not fair to say we are covering more people when we are bankrupting our States. We are not covering anybody if we are pushing the cost off on someone else.

So I appreciate the senior Senator from Georgia raising that point, and I associate myself with Governor Schwarzenegger and his remarks this morning about urging us not to force unfunded mandates on our States.

The Senator from Texas.

Mr. CORNYN. If I can respond to the senior and junior Senators from Georgia on this point, my State population is 24 million. Over a 10-year period of time, this is a $20 billion unfunded mandate—$20 billion. Of course, we know—or at least we read and hear from some in the press—that not all States are going to be treated the same. That was, in fact, an inducement on the part of some Senators to vote for the bill—to be one of the 60 votes—because they were either going to get a sweetener, in terms of being held harmless for at least a portion of that, or in the case of Nebraska, I guess all of it.

That strikes me as fundamentally unfair, but it also demonstrates the flaw in the way this bill has been negotiated. In order to try to get to the 60 votes, there has basically been a pay-to-play sort of approach to this, and it is just repulsive to me, frankly. Certainly, a lot of my constituents would wonder: What kind of games are going on there?

I know the Senator from South Carolina has some thoughts about that.

Mr. GRAHAM. Well, this started out as a noble effort to reform health care because it needs reforming. The inflationary cost of the government is unsustainable. Medicare and Medicaid, as the Senators from Georgia indicated, are becoming huge problems that are unsustainable. Medicare is $36 trillion underfunded.

Now, what does that mean? It means that over the next 75 years, there is a $36 trillion shortfall of money to pay the benefits that have been promised, and that has to be dealt with.

What we are doing to Medicare makes the problem worse, not better. Medicaid is the largest expense in my State. It is a matching program. So listen to this—if you are out there on a Sunday with nothing else to do but listen to me. If you don't live in Nebraska, here is what is coming your way. Your State will be required to cover more people under Medicaid because the eligibility goes up to 133 percent above poverty, which is an increase over the current system. So throughout the Nation, there are going to be thousands more people enrolled in Medicaid, and every State, except one, is going to have to come up with matching money.

I have 12 percent unemployment in South Carolina. My State is on its knees. I have a 31-percent African American population in South Carolina. Yet how did the majority get the 60th vote on this bill? It was the weekend before Christmas, and they were one vote short—here is what they did to get that one vote. They had a deal cooked up that no one knew about but the two people talking. There was no input from anybody other than the majority leader and the Senator from Nebraska. After that meeting was over, they came up with a 380-page amendment to a 2,000-page bill. They filed it yesterday, and we made them read it. We heard it for the first time yesterday. Then the majority leader filled up the tree so that there is no ability by any Republican or Democrat to amend their work product.

This is a transparent new way of doing business: you cook up a deal in a back room—that is essentially sleazy, in my view—to allow one State, in order to get that vote, be held harmless for Medicare enrollees, and the rest of us have to go home and hear our constituents say: Why can't you in South Carolina and Georgia get that deal? What kind of Senator are you?

Well, I will tell you; this is the kind of Senators we are. We are not going to do that. We are not going to put the whole Nation at risk and take a broken system and make it worse just to get a vote. No way in hell.

On abortion, you are either for it or against it or you are indifferent. You can be whatever you are on abortion and be just as good an American as I am. I am pro-life and proud of it. Most of us in America, whether you are pro-choice or pro-life, don't want our Federal taxpayer dollars to be used to pay

for abortions. For 32 years, the Hyde amendment has been the law of the land, preventing taxpayer dollars to be used for abortion. In this health care reform, guess what. That is exactly what is going to happen. There is a brave Democrat in the Congress—Bart Stupak, from a blue State—who stood up to his Democratic leadership and said: I will not vote for a bill that allows Federal taxpayer dollars in the form of subsidies to be used to fund abortion because I find that morally offensive, and I think most Americans agree with me. He brought the House to its knees, saying: You will not pass this bill to use federally funded Federal dollars to fund abortion.

What did he get out of it? Nothing. Not one thing for Wisconsin. He got out of that deal the pride of knowing that he stood up for the unborn.

So the bill comes to the Senate, and Senator NELSON from Nebraska tries to introduce the Stupak language that would be an absolute bar from using taxpayer dollars to fund abortion. He lost that amendment. He said he could not vote for a bill that would allow taxpayer dollars to be used to fund abortion. But then he gets in a room with Senator REID, and he comes up with a compromise and he claims it solves the problem. The problem is, his claim is not accepted by all those who follow this. The compromise he has achieved on abortion is a miserable failure.

Congressman STUPAK says it is unacceptable. The National Right to Life Committee says it is unacceptable. The Nebraska Right to Life Committee says it is unacceptable. The Council of Catholic Bishops says it is unacceptable. There is not one pro-life group in this country that believes Senator NELSON has protected the rights of the unborn. So how, in good conscience, do you vote for a bill when that was the big issue?

At the end of the day—one last thought—this bill would make an Enron accountant blush. They are talking about how it lowers the deficit by $132 billion. But they do not tell you that the $247 billion doctor fix is not in the bill. What am I saying? Over the next 10 years, doctors, under the 1997 balanced budget agreement, will have $247 billion taken out of their practices unless Congress acts.

Since 1997, Congress, every year, has stepped to the plate and forgiven that cut, which is double digits. Everybody knows we are going to do that. But when it came to health care reform, they left out the doctor fix because if you include it, it no longer is revenue neutral. It no longer does what they say.

They say this bill cuts the deficit by $132 billion, but if you include the $247 billion, it runs up the deficit in the first 10 years, and in the second 10 years it adds $2 trillion to the deficit.

Long story short, this is what Enron did. People went to jail for doing this in the private sector. They took the liabilities of the company and they hid them, making their balance sheet look better than it actually was. So when you hear this reduces the deficit by $132 billion, they took out a liability that they know we are going to fund, just to cook the books.

If this is going to be OK for the country, then we have no hope as a Nation of ever solving any hard problem. And I would like to say to my colleagues: I know you want to be home. I know everybody on the other side wants to be home. I know you want to find ways to solve hard problems. Troops in Afghanistan want to be home, too. At least they are away from home for a noble purpose. We are here trying to stop a legislative process that, if it becomes legitimate—if this becomes the OK way of doing business, giving one Senator a deal you will not give anybody else and putting the whole country at risk just to get one vote—then I hope the American people will rise up in righteous indignation and throw us all out because nobody should be representing the country this way.

Mr. CHAMBLISS. The Senator from South Carolina raises the point about this bill being revenue neutral and it actually decreases the deficit. How do they achieve that? They achieve that through some truly Enron accounting, as the Senator from South Carolina just said. But here is what happens: There is a certain amount of money that is projected by CBO to be generated in insurance premiums being paid by young individuals across this country under what is called the CLASS Act. The CLASS Act is a new health care-generated program, a new entitlement program that is included in this bill that is going to provide long-term care benefits for young, healthy Americans who, ultimately, are going to become invalid and need that long-term care.

Well, the fallacy in the numbers game that is being played is that CBO is saying it is true there will be a projection that we are going to save—the projection they are using says we are going to generate premiums from these young people who are not going to be entitled to the benefits under this bill for 20, 30, 40 years from now. But even CBO recognizes that when these benefits begin being paid out, there is going to be an entitlement created that is going to blow the budget of this particular new program all the way out the top.

In fact, the chairman of the Budget Committee, a Democrat from North Dakota whom I admire and respect so much, has even said this particular provision in this bill is a Ponzi scheme. It is something Bernie Madoff would love. Yet here they are with straight faces on the other side of the aisle coming in and saying we are really going to reduce the deficit by passing this provision called the CLASS Act. It is beyond me how anybody, with a straight face, can say that is actually a fact.

Mr. ISAKSON. Will the Senator yield?

Mr. CHAMBLISS. Absolutely.

Mr. ISAKSON. Isn't it true that is what is wrong with Social Security today? We have spent it for years and years rather than putting it in a trust fund, and now the baby boomers are going: The money is not there? Isn't that the same thing?

Mr. CHAMBLISS. The Senator is exactly right, and exactly the same situation with Medicare.

Mr. ISAKSON. Just a question on a followup on the fiscal part the Senator from South Carolina brought up. It is also still true that the taxes on this bill begin in 11 days—January 1, 2010—but the benefits begin on January 1, 2014, and in that score of the first 10 years of cost, you have years of program that are not costing anything while you are raising revenues. So it is a ruse and a masking of the actual fiscal effect on the United States of America.

Mr. CHAMBLISS. The only way Senator REID could get the score that he kept going back and forth with the Congressional Budget Office on was to make sure the taxes started immediately. And they will. He has increased taxes by $26 billion to come up with a proposal that he says is revenue neutral. That is an additional $26 billion. So it makes it a total of $518.5 billion in new taxes that are going to be paid by hard-working, tax-paying Americans, and no benefits under this bill are going to start accruing until the year 2014.

Mr. CORNYN. Will my friend yield for a question?

Mr. CHAMBLISS. Absolutely.

Mr. CORNYN. I ask the senior Senator from Georgia, does he remember this statement by President Obama? He said he will not sign a plan that adds one dime to our deficits, either now or in the future, period. Yet David Broder, perhaps one of the most respected journalists here in Washington, DC, who has been around a long time, said he has talked to all the experts and everybody he has talked to said these bills as they stand are ''budget-busters.'' Of course, I am sure the Senator also remembers a Washington Post-ABC poll that said 66 percent of those who responded to the poll think this bill will make the deficit worse, not better.

In other words, we have a credibility problem between what is being promised here by the President and presumably by the proponents of this bill and the American people because they simply do not buy it. They do not believe it. Maybe that is why that earlier number from the Rasmussen poll said a majority of Americans do not want us to pass this bill but, rather, want us to start over and take a step-by-step or incremental approach.

Mr. CHAMBLISS. There is just no question but that the American people understand this. They get it. When we talk about cutting Medicare by $450 billion, do they really not think the quality of care under Medicare is going

to be diminished? Of course it is. Do the American people really think we are not going to have an increase in the deficit when we are going to have almost a trillion-dollar bill in real, live dollars that is going to be passed by this body in the next couple of days, in all probability? Surely the American people get that. They know this is going to increase the cost of health care and it is going to increase the deficit. That is why they are opposed to this.

Mr. GRAHAM. Will the Senator yield for another question?

Mr. CHAMBLISS. Sure.

Mr. GRAHAM. Let's talk about the CLASS Act a little bit more. It is a new program that doesn't exist today where the Federal Government, as I understand it, will be offering long-term health care insurance to the American people. It is a voluntary program at first, just like everything else around here. Guess who is going to sign up. It is called adverse selection. The sickest people in the country are going to sign up.

Under the bill as it is written, it is just like what Senator ISAKSON said about the underlying bill. You collect taxes for 10 years; you pay out benefits for 6. That is the way you get the money to make the numbers come out right.

Guess what happens in this CLASS Act, the new program no one has heard much about. You start collecting premiums in 2011, but you don't pay any benefits until 2016. Guess what happens. That generates $73 billion of money to be used to say to the American people that this bill is paid for. But when you ask the CBO about what happens after 2016, they say that by 2029, I think it is, the whole thing falls apart because the only people in the program are the sickest folks because it is a voluntary program, and at the end of the day, you have created a new entitlement, and everybody in this body is going to be rushing to subsidize premiums and get more people into this system. It will be another entitlement that grows, and CBO says it will be a death blow to our fiscal soundness.

I ask the Senator from Georgia, when Senator CONRAD, whom we all respect, said this is a giant Ponzi scheme that Bernie Madoff would have been proud of, do you think that is what he meant? You collect premiums and you make it look as if you have money you really do not have and you put off paying out benefits. And at the end of the day, would the Senator agree with me—I have a letter from October 23, 2009, from Senators CONRAD, LANDRIEU, LINCOLN, WARNER, LIEBERMAN, BAYH, and NELSON to the majority leader saying: Please take the CLASS Act out of the bill.

Would the Senator agree that the CLASS Act is still in the bill and that anybody who votes to send this off to the President to become law has become a coconspirator to the giant Ponzi scheme?

Mr. CHAMBLISS. I don't think there is any question about that. The Senator is exactly right. It is what we in Washington call fuzzy math—utilization of money from one pocket to pay for something on the other side. At the end of the day, it just does not add up. The Senator from North Dakota was exactly right, it is a huge Ponzi scheme.

I ask unanimous consent to have printed in the RECORD the letter dated October 23, 2009, just referenced by the Senator from South Carolina.

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

U.S. SENATE,
Washington, DC, October 23, 2009.

Hon. HARRY REID,
Majority Leader, The Capitol,
Washington, DC.

DEAR LEADER REID: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee bill known as the CLASS Act in the merged bill.

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger.

While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by $73 billion over ten years. But nearly all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit point of order in the Senate.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

Slowing the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The CLASS Act bends the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time and increase deficits.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD.
MARY L. LANDRIEU.
BLANCHE L. LINCOLN.
MARK R. WARNER.
JOSEPH I. LIEBERMAN.
EVAN BAYH.
BEN NELSON.
U.S. Senators.

Mr. CORNYN. I am wondering if the Senator would yield for a question since we have a unanimous consent for a colloquy.

The Senator was talking about this a little earlier, but one of the things that has not been adequately discussed and because of the way this bill has been railroaded and we have been denied an opportunity to offer amendments and we will be voting on the bill on Christmas Eve, as it is currently scheduled, I want to ask about the impact on businesses. You were in the real estate business and employed a number of people in your company. You had to meet a payroll and make sure you ended up in the black and not in the red.

One of the things the National Federation of Independent Business said was that this bill will actually increase health care costs for businesses and the cost of doing business. I can't imagine anything worse that we could be doing during a recession, during a time when unemployment is at 10 percent, than making it more expensive to do business and thus keep people on your payroll. Won't that be the impact of this, with higher taxes, with increased health care costs going to employers, that it is actually going to make the unemployment problem worse rather than better?

Mr. ISAKSON. I think the Senator from Texas is exactly right. I will be the first to tell you, I am in the process of reading the 400-some-odd page managers' amendment. I haven't read all of it yet. It does take out the public option, which, by the way, that was originally in. It still may reappear at some date in the future. That was a real killer. That raised tremendous costs. In fact, it made it more beneficial for a company not to provide insurance and pay the fine and put people in the government option. That is not in the bill now, I understand that.

But let me tell you what is in the bill. What is in the bill are a number of taxes on small businesses that produce medical devices and medical treatments. You know as well as I do that when the government raises your taxes, you have to raise your price to the consumer. What does that mean? It is not lowering the cost of health care. It is, through the tax mechanism, raising the cost of health care, either to the insurance company that is in the exchange or to Medicaid or to Medicare or to the individual person in terms of their copayments.

You cannot hide the fact that when you are raising those types of revenues—$514 billion; $50 billion a year over 10 years—that money is going to ultimately be paid by the consumer of health care. It may be paid by the company on its tax return, but it is a pass-through cost that they are going to pass through to their consumer, which in turn is going to put more pressure on whoever insures that consumer, if, in fact, they are insured. So anytime

the government raises taxes, it raises the cost of living for the American people. That is just a common, well-known fact. The Senator is exactly correct.

Mr. CHAMBLISS. We have talked a little bit about the negotiations that took place behind closed doors over the last few days. It is unfortunate that we have gotten to the point in this body and on this particular piece of legislation where the issue of abortion has injected itself into meaningful and affordable health care reform measures. But that is, in fact, what has happened. Similar to my friend from South Carolina, I am pro-life. We all are. I am very proud to be and have a strong voting record on that. The law of the land for well over 30 years has been that no Federal funds should be used to fund abortions. It makes no difference whether you are in one part of the country or the other; that is the law. That is the way it ought to be. It ought not to be changed.

We have had any number of votes on abortion issues over the years. In every instance, we have failed to pass a law that would provide for the use of Federal funds for abortions. That is changing. Irrespective of what the Senator from Nebraska thinks he negotiated, that has changed.

I have three letters I will include for the RECORD. One is pretty interesting because it is from a group of African-American ministers in my home State. This group is headed by Bishop Wellington Boone. He wrote me a letter yesterday. Here is part of what he says:

We cannot emphasize enough that abortion is not health care.

He is absolutely right.

There is also a letter from Cindy O'Keary, executive director of the HOPE Center in Woodstock, GA, who is appalled at the discussions and the fact that we now are going to be using Federal money to fund abortions, and also a letter from Sadie Fields, State chairman of the Georgia Christian Alliance, imploring us not to pass any kind of bill that sets the precedent of providing Federal funds for the use of abortion.

I ask unanimous consent to have all three letters printed in the RECORD.

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

WELLINGTON BOONE MINISTRIES,
Norcross, GA, December 19, 2009.

Senator SAXBY CHAMBLISS,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR CHAMBLISS: We would like to take the time to thank you for your service to our country and to the citizens of Georgia. We thank you and your colleagues in the Senate who have stood against the terrible healthcare bill which mocks reform and increases taxes, debt and federal power while decreasing the freedom that Georgians value so highly. All of these concerns, however, pale in comparison to fact that the Senate version of the bill opens the door for the federal funding of abortion.

Those of us who have stood for life over the years have long known that the abortion lobby would never be satisfied with the mere legalization of abortion: they want it to be paid for by taxpayers. Many of your nominally pro-life colleagues have proven that their support of human life has a price: the Manager's amendment does nothing to prevent federal funds from paying for abortion in the federally subsidized healthcare exchanges. The charade that this is some sort of compromise is insulting not only to pro-life activists, but to the overwhelming majority of Americans who don't believe that taxpayer money should pay for abortions.

Who will be aborted with this federal money? In Georgia, 56% of all abortions are performed on black women and nationwide blacks have lost 35% of their population to abortion since Roe v. Wade. The Senate also opened the door for the federal funding of abortion among the indigenous peoples of this country by excluding the Hyde amendment from the reauthorization of the Indian Health Service. Perhaps your colleagues in the Senate are not satisfied with how few American Indians there are left.

We cannot emphasize enough that abortion is NOT healthcare. It seems some members of the Senate want to take a practice that was supposed to be ''safe, legal and rare'' and make it ''common, legal and subsidized.'' To overturn longstanding policy restricting the federal funding of the destruction of American lives while calling it ''healthcare'' is nothing short of evil.

We remain strongly opposed to the use of our tax dollars to fund abortion. We ask you, as our Senator, not to let your colleagues forget the line they are crossing if they vote for cloture. Only time will tell if they can escape judgment for their vote in their home states. But there is one Judgment not one of us can escape. Your colleagues who have not yet turned their backs on that Judge would do well to remember this as they cast their votes.

BISHOP WELLINGTON BOONE,
Fellowship of International Churches.
DR. CREFLO DOLLAR,
Creflo Dollar Ministries.
DR. ALVEDA KING,
King for America.
MR. DAN BECKER,
Georgia Right to Life.

From: Cindy O'Leary [cindyhopecenter@bellsouth.net].
Sent: Saturday, December 19, 2009, 4:48 p.m.
To: Harman, Charlie (Chambliss).
Subject: Senate Discussion and Vote on Health Care Legislation.

SENATOR CHAMBLISS, As a registered nurse and the executive director for a pregnancy resource center that helps women and men explore alternatives to abortion as they seek solutions to what are often unexpected or unplanned pregnancies, I am gravely concerned about the potential impact of government-subsidized abortions, not only for the unborn, but for their parents who may feel overwhelmingly swayed by economic factors to make the most devastatingly wrong decision of their lives.

I want to thank you for standing strong tomorrow on the floor of the Senate in expressing the views of your constituents and, according to the recent CNN poll which revealed that six out of ten Americans are opposed to federal funding of abortion, we the people of the United States, as you promote a NO vote on the current health care legislation before the Senate. The only conscionable YES vote will come later for legislation that explicitly excludes the use of federal funds for abortion.

It is my understanding that the so-called ''compromise'' language included in Senator Reid's Manager's Amendment would actually ensure that, for the first time EVER, federal funds would be made available for the payment of elective abortions. It is also my understanding that the Manager's Amendment rejects other ''compromise'' proposals on abortion that would have codified the House-approved ''Weldon Amendment'' which prohibits government bodies from discriminating against health care providers. Such compromises included an ''individual'' opt-out from abortion coverage, which the Manager's Amendment does not. The Manager's Amendment rejects even the most broadly accepted agreements on this issue.

Thank you for your courageous support for life and for fighting against allowing the government of the people and for the people to pick up the tab for abortions in America.

CINDY O'LEARY, BSN,
Executive Director, The HOPE Center.

GEORGIA CHRISTIAN ALLIANCE,
December 19, 2009.

Hon. SAXBY CHAMBLISS,
U.S. Senate, Washington, DC.

DEAR SENATOR CHAMBLISS: The Georgia Christian Alliance and its 65,000-plus supporters in Georgia strongly object to the language contained in the newest version of the Democrat's Health Care Reform bill that ensures, for the first time ever, federal tax dollars will pay for elective abortions.

If this bill passes, millions of pro-life Americans who believe that abortion is biblically and morally wrong will be forced to fund an act that takes an innocent human life. A Gallup Poll conducted in May 2009 finds 51% of Americans identifying themselves as ''pro life'' on the issue of abortion and 42% identifying themselves as ''pro choice.'' This is the first time a majority of U.S. adults have identified themselves as pro-life since Gallup began asking this question in 1995.

For weeks, Democrat Senators and Representatives have ensured pro-life Americans they would never vote for a bill that contained federal funding for abortion. It would seem they sold their pro-life position for a bowl of porridge. We are deeply disappointed that they have gone back on their word, and ask you and your colleagues in the U.S. Senate to stand strong for innocent life as this bill moves forward in any Senate vote and in any subsequent conference committee.

Sincerely,

SADIE FIELDS,
State Chairman.

Mr. CHAMBLISS. Madam President, in closing, let me say, the Senator from South Carolina said it strongly and he is right: We have reached a new day in this body. We have had deals cut behind closed doors that are going to provide benefits for individual Senators and their States—whether Vermont, New Hampshire, Nebraska, Florida, or wherever—and that are going to require those of us who didn't have the opportunity to participate in the discussions and negotiations on this bill to represent to our citizens that they are going to have to pay more for services than everybody all across America gets. There is nothing right about that. There is nothing fair about it.

I daresay, I have some relatives who live in Nebraska. They have to be embarrassed and ashamed about this. They are going to be getting a huge benefit simply because the Democrats needed 60 votes to pass the health care bill.

Mr. GRAHAM. One last thought, if I may. The Senator mentioned the people in Nebraska. I know there are good, hard-working people all over the country, particularly in Nebraska. A lot has been said about Nebraska. I hope the people in Nebraska will be heard. This is not over. They may get 60 votes in the next couple days, but this is not over. We are going into the fourth quarter, and the most valuable player on our team is the American people. Speak up, speak out. If you don't like what is going on, if you don't like the phony baloney accounting, if you are upset about your taxpayer dollars being used to fund abortions, speak up. If you think there is a better way of doing business, let us know about it. There is a long way to go. It has to go back to the House. The House has a say. One Senator indicated the House better take it or leave it. That is not good government. That is not the way it works. Three of us have been in the House. I want you to know this is far from over. Public opinion matters to us all. To the American people who are concerned about this being a done deal, it is not. You can change the outcome. I hope you will get involved. At the end of the day, it is your country we are talking about.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Madam President, it has been more than a month since the majority leader moved to proceed to the health care bill before us today. This bill will provide real reform for our Nation's flawed health care system. This bill is the product of years of hard work, study, and deliberation in both the Finance Committee and the HELP Committee—and I mean years—all transparent, all aboveboard, all out in the open. In fact, in the Finance Committee, we initiated a new requirement that all amendments to the bill would have to be posted in advance on the Internet so everybody could know what they were, the same with the bill itself. The mark was on the Internet for a couple 3 days before we even went to markup. It is unprecedented how open and transparent the process has been. The same is true in the HELP Committee.

The culmination of these efforts has been the weeks of debate on this bill in the Senate. These provisions have been in the public domain for a long time. It is true there could be minor changes here and there, but most of this has been in the public domain for a long time. We have considered numerous amendments. We have engaged in a full and healthy discussion. The bill before us is fully paid for. It is important to keep reminding colleagues over and over again: This is fully paid for. Don't take my word for it. That is what the CBO said. The American people trust and realize, according to the Congressional Budget Office, a nonpartisan organization, that this bill is fully paid for. It does not add one thin dime to the deficit. You are going to hear others who don't have their own proposals just want to be negative, want to try to shoot holes in this, try to say it adds to the deficit. That is their opinion. That is not the opinion of the CBO. CBO says it does not add one thin dime.

This bill will also reduce the Federal deficit in the short term and over the long term. It reduces the Federal deficit. We are so very concerned about deficits. We in the Congress are and the country is. We have to begin as soon as we can to start getting those deficits down and the national debt lowered. This health care reform bill not only provides health insurance coverage and reforms the insurance industry dramatically, it also takes the steps of lowering the deficit and lowering the long-term debt.

Let me quote from the Congressional Budget Office letter of yesterday:

> CBO and [Joint Committee on Taxation] estimate that, on balance, the direct spending and revenue effects of enacting the Patient Protection and Affordable Care Act incorporating the managers' amendment would yield a net reduction in federal deficits of $132 billion over the [10-year] period.

A net reduction of $132 billion. That is even better than the merged bill was just before we included the managers' amendment. That was a $130 reduction in the national deficit. With the managers' amendment, according to the CBO, there is a net reduction in the Federal deficit of $132 billion over the 10-year period. What about later? Often people say: Gee, I hear you, Senator, you are taking care of things in the short term, but you are enacting legislation that will have an adverse long-term effect. That is what you guys do back there.

You hear that often. Let me disclose what the Congressional Budget Office says about that. This legislation will reduce the deficit markedly in the out-years. Here is what the CBO says in a letter released today:

> All told, the [Congressional Budget Office] expects that the legislation, if enacted, would reduce federal budget deficits over the decade after 2019 relative to those projected under current law—with a total effect during that decade that is in the broad range [of] between one-quarter and one-half percent of GDP.

What are they saying? They are saying that in the second 10 years, the deficit will be reduced between one-quarter and one-half percent of GDP. That is between $630 billion and $1.3 trillion. That is real money. We are going to reduce the Federal deficit by this legislation alone. Let's take the between $630 billion and $1.3 trillion—roughly, $1 trillion in the next decade. That is important. That is significant. That is a good start.

The legislation before us will extend insurance coverage to more than 30 million Americans. Think of that, 30 million Americans who today do not have insurance will get health insurance. That is so important. I have forgotten the exact figure, but I remember there was a Harvard study that concluded that 45,000 Americans die every year because they have no health insurance. Obviously, people without health insurance die earlier, at an earlier age. Just for the sake of their own health, it is good those people get health insurance, let alone the benefit to hospitals by reducing uncompensated care.

This legislation will increase insurance coverage to more than 30 million Americans. I have just been passed a note that people have a 40-percent higher chance of dying without health insurance. We are saying to those folks, those 31 million Americans, we are going to figure out a way so you have health insurance so you do not have that 40-percent higher risk of death.

Here is what CBO says about coverage:

> By 2019, the CBO and [Joint Committee on Taxation] estimate that the number of nonelderly people who are uninsured will be reduced by about 31 million.

CBO goes on to say:

> Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from 83 percent currently to about 94 percent.

That is 94 percent of the folks in our country, excluding seniors, because they have insurance under Medicare, excluding them and excluding the unauthorized, the total number of Americans who have health insurance will rise from the current number of 83 percent to about 94 percent.

This legislation will drive down premium costs for virtually all of us. It will drive down premium costs for virtually all. In an earlier letter, the CBO indicated premiums would go down for roughly 93 percent of Americans under the underlying bill. Premiums would go down about 93 percent for Americans. I was going to put a table in the record, but our rules don't allow us to put tables in, so I summarized. The conclusion of that summary is 93 percent of Americans will experience lower premiums—not dramatic for some folks but nevertheless down, and down is better than not down.

Insurance costs would go down significantly for those receiving tax credits in the new insurance exchanges. It will protect consumers from harmful insurance company practices. This is so important. As you know, no longer will insurance companies be able to deny coverage for those with preexisting conditions. It is an outrage how much insurance companies deny coverage based on preexisting conditions. We all hear stories many times, if not from direct family members, from friends of family who run into this. It is so common, especially in the individual market as people buy insurance for themselves. Insurance companies deny coverage, deny giving health insurance to somebody because of a preexisting condition. It is wrong.

No longer will insurance companies be able to drop coverage for those who are sick. That is very important too. Companies often rescind willy-nilly.

They found something in the background of the person, you didn't tell us about that so we are rescinding your policy. That is not right. That is just not right. We prevent that from happening in this legislation.

It will also improve choice and competition in the insurance market. We talk a lot about choice and competition. This legislation provides more choice in choosing policies and more competition in the insurance market. It will also create a true marketplace where plans compete on cost and quality rather than on their ability to cherry-pick the healthiest among us.

It will represent the largest tax cut for American families that Congress has passed since 2001. This legislation includes the largest tax cut for American families that Congress has passed since that tax cut bill in 2001, the largest. It is the tax credits people will receive to help them buy insurance. That totals up, I think, to $440 billion. I have forgotten the exact figures. But this is the largest tax cut for American families since 2001. It will provide billions of dollars in tax credits to help families, workers, and small businesses to buy quality, affordable health care insurance. The managers' amendment makes this good bill even better. It will provide even more consumer protections against harmful insurance industry practices.

For example, it will hold companies accountable for excessive premium rate increases. It will require them to spend more on consumer benefits and less on administrative costs and profits. That is new. That is even better consumer protection compared with the underlying bill. It will restrict the ability of health plans to impose annual limits on benefits. That is new, restricting the ability of health plans to impose annual limits on benefits. It is wrong if you have an insurance policy that, lo and behold, the company says: We didn't know you were going to be that sick so we stopped the benefits you can get, annually and also lifetime. We do both. We restrict the ability of health plans to impose not only annual limits but also lifetime limits on benefits.

This managers' package will ensure that companies cannot discriminate against children with preexisting conditions and do so right away, beginning with plans that become effective midyear next year. The preexisting condition restriction would ordinarily not take effect for a couple years, but for children the preexisting condition prohibition will take effect right away. There are other provisions to help people between now and 2014. There is high-risk pooling, for example, lots of different provisions in this bill which will help people get good benefits and protection very quickly.

This legislation will provide tax credits to even more small businesses. The managers' amendment will provide even more tax credits than the underlying bill. These benefits will now be available right away, in 2010. It is also a concern when will the tax credits for small business go into effect—shouldn't they go into effect earlier. Under this managers' amendment, these benefits will be available in 2010.

This will also provide more health insurance choices through a new multistate option. That option offers consumers the same health insurance Congress has today—no small matter. It will extend extra funding for the Children's Health Insurance Program for 2 additional years. We are all very concerned about kids' health care. The children's health care program has done a pretty good job. This has been extended, under the managers' amendment, for an additional 2 years. It will do even more to control rising health care costs and reward even more providers for providing quality care to seniors through the Medicare Program. It will invest $10 billion in community health centers. They are so important, community health centers, for folks who need help right away and don't have insurance, just need the care right away. Especially in rural communities, it will provide access to critical care where often that care is most needed.

These are the reforms which Americans have been waiting for, for decades. Americans are waiting for these changes. They are waiting for these reforms and have been for a long time. Decades may be an understatement. Our health insurance system just doesn't do what it should for Americans, the people we represent. Finally, we are taking a very significant first step to providing those reforms. These are reforms American families, workers, and businesses desperately need. They are reforms on which our economic stability depends. That is no small matter either. If we get our insurance costs under control, that is more economic stability for everyone. It is not just for families who don't know what the insurance company is or is not going to do, it is for small businesses that don't know whether premiums will be up or by how much next year. Why? It is more economic stability for families and small businesses and soon more economic stability for budgets, State budgets, our Federal budget.

We need to get a little more control over all the excessive costs that are going up, and also the volatility, the yo-yo effect that premiums have and out-of-pocket cost impositions have on people. This will help them very significantly.

So by and large, to be honest—I know this sounds a little naive, perhaps—I do not know why this bill does not get an overwhelming endorsement. This is a big vote on both sides of the aisle. Then we can, next year, keep going from there; add new provisions that need to be added, correct mistakes that probably this legislation is going to have, but work together because most Americans want us to work together back here. They do not like us being partisan or political.

I must say, this place is getting a little more partisan over the last couple years than it was earlier. It is not what the American people want. They want us to do our job, do what is right. This bill clearly is in the bounds of reasonableness of what is right and what is the right thing to do to get control of our health care system.

Again, I hope we can get this passed by a large margin. It will pass. But I would like it passed by a large margin.

Madam President, I now yield 20 minutes to the Senator from Rhode Island, Mr. WHITEHOUSE.

The ACTING PRESIDENT pro tempore. The Senator from Rhode Island.

Mr. WHITEHOUSE. Madam President, I thank Chairman BAUCUS.

As we are here in the Senate today, Washington rests under a blanket of snow, reminding us here of the Christmas spirit across the Nation, the spirit that is bringing families happily together for the holidays. Unfortunately, a different spirit has descended on this Senate. The spirit that has descended on the Senate is one described by Chief Justice John Marshall back in the Burr trial: ''those malignant and vindictive passions which . . . rage in the bosoms of contending parties struggling for power.''

Two-time Pulitzer Prize winner Richard Hofstadter captured some examples in his famous essay, ''The Paranoid Style in American Politics.'' The malignant and vindictive passions often arise, he points out, when an aggrieved minority believes that ''America has been largely taken away from them and their kind, though they are determined to try to repossess it and to prevent the final destructive act of subversion.''

Does that sound familiar in this health care debate? Forty years ago, he wrote that. Hofstadter continued, those aggrieved fear what he described as ''the now familiar sustained conspiracy''—familiar then, 40 years ago; persistent now—whose supposed purpose, Hofstadter described, is ''to undermine free capitalism, to bring the economy under the direction of the federal government, and to pave the way for socialism. . . .'' Again, familiar words here today.

More than 50 years ago, he wrote of the dangers of an aggrieved rightwing minority, with the power to create what he called ''a political climate in which the rational pursuit of our well-being and safety would become impossible''—''a political [environment] in which the rational pursuit of our well-being and safety would become impossible.''

The malignant and vindictive passions that have descended on the Senate are busily creating just such a political climate. Far from appealing to the better angels of our nature, too many colleagues are embarked on a desperate no-holds-barred mission of propaganda, falsehood, obstruction, and fear.

History cautions us of the excesses to which these malignant, vindictive passions can ultimately lead: tumbrels have rolled through taunting crowds; broken glass has sparkled in darkened streets; ''strange fruit'' has hung from southern trees; even this great institution of government that we share has cowered before a tail gunner waving secret lists.

Those malignant moments rightly earned what Lord Acton called ''the undying penalty which history has the power to inflict on wrong.'' But history also reminds us that in the heat of those vindictive passions, some people earnestly believed they were justified. Such is the human capacity for intoxication by those malignant and vindictive political passions Chief Justice Marshall described. I ask my colleagues to consider what judgment history will inflict on this current spirit that has descended on the Senate.

Let's look at what current observers are saying as a possible early indicator of the judgment history will inflict. Recently, the editor of the Manchester Journal Inquirer editorial page wrote of the current GOP, which he called this ''once great and now mostly shameful party,'' that it ''has gone crazy,'' is ''more and more dominated by the lunatic fringe,'' and has ''poisoned itself with hate.'' He concluded, they ''no longer want to govern. They want to emote.''

A well-regarded Philadelphia columnist recently wrote of the ''conservative paranoia'' and ''lunacy'' on the Republican right. The respected Maureen Dowd, in her eulogy for her friend, William Safire, lamented the ''vile and vitriol of today's howling pack of conservative pundits.''

A Washington Post writer with a quarter century of experience observing government, married to a Bush administration official, noted about the House health care bill, ''the appalling amount of misinformation being peddled by its opponents''; she called it a ''flood of sheer factual misstatements about the health-care bill,'' and noted that ''[t]he falsehood-peddling began at the top. . . .''

The respected head of the Mayo Clinic described recent health care antics as ''scare tactics'' and ''mud.''

Congress itself is not immune. Many of us felt President Bush was less than truthful, yet not one of us yelled out ''You lie!'' at a President during a joint session of Congress. Through panics and depressions, through world wars and civil wars, no one ever has—never—until President Obama delivered his first address. And this September, 179 Republicans in the House voted to support their heckler comrade. Here in the Senate, this month, one of our Republican colleagues regretted, ''Why didn't I say that?''

A Nobel prize-winning economist recently concluded thus:

> The takeover of the Republican Party by the irrational right is no laughing matter. Something unprecedented is happening here—and it's very bad for America.

History's current verdict is not promising.

How are these unprecedented passions manifest in the Senate? Well, several ways.

First, through a campaign of obstruction and delay affecting every single aspect of the Senate's business. We have crossed the mark of over 100 filibusters and acts of procedural obstruction in less than 1 year. Never since the founding of the Republic—not even in the bitter sentiments preceding the Civil War—was such a thing ever seen in this body. It is unprecedented.

Second, through a campaign of falsehood: about death panels, and cuts to Medicare benefits, and benefits for illegal aliens, and bureaucrats to be parachuted in between you and your doctor. Our colleagues terrify the public with this parade of imagined horrors. They whip up concerns and anxiety about ''socialized medicine'' and careening deficits, and then they tell us: The public is concerned about the bill. Really?

Third, we see it in bad behavior. We see it in the long hours of reading by the clerks our Republican colleagues have forced. We see it in Christmases and holidays ruined by the Republicans for our loyal and professional Senate employees.

It is fine for me. It is fine for the Presiding Officer. We signed up for this job. But why ruin it for all the employees condemned by the Republicans to be here?

We see it in simple agreements for Senators to speak broken. We see it, tragically, in gentle and distinguished Members, true noblemen of the Senate, who have built reputations of honor and trustworthiness over decades being forced to break their word, and double-cross their dearest friends and colleagues. We see it in public attacks in the press by Senators against the parliamentary staff.

The parliamentary staff is nonpartisan; they are professional employees of the Senate who cannot answer back. Attacking them is worse than kicking a man when he is down. Attacking them is kicking a man who is forbidden to hit back. It is dishonorable.

The lowest of the low was the Republican vote against funding and supporting our troops in the field in a time of war. As a device to stall health care, they tried to stop the appropriation of funds for our soldiers. There is no excuse for that. From that there is no return. Every single Republican Member was willing to vote against cloture on funding our troops, and they admitted it was a tactic to obstruct health care reform.

The Secretary of Defense warned us all that a ''no'' vote would immediately create a ''serious disruption in the worldwide activities of the Department of Defense.'' And yet every one of them was willing to vote ''no.'' Almost all of them did vote ''no.'' Some stayed away, but that is the same as ''no'' when you need 60 ''yes'' votes to proceed. Voting ''no'' and hiding from the vote are the same result. And for those of us here on the floor to see it, it was clear: The three who voted ''yes'' did not cast their ''yes'' votes until all 60 Democratic votes had been tallied and it was clear that the result was a foregone conclusion.

And why? Why all this discord and discourtesy, all this unprecedented, destructive action? All to break the momentum of our new, young President. They are desperate to break this President. They have ardent supporters who are nearly hysterical at the very election of President Barack Obama: the ''birthers,'' the fanatics, the people running around in rightwing militias and Aryan support groups. It is unbearable to them that President Barack Obama should exist. That is one powerful reason.

It is not the only one. The insurance industry, one of the most powerful lobbies in politics, is another reason. The bad behavior you see on the Senate floor is the last thrashing throes of the health insurance industry as it watches its business model die. You who are watching and listening know this business model if you or a loved one has been sick: the business model that will not insure you if they think you will get sick or if you have a preexisting condition; the business model that, if you are insured and you do get sick, job one is to find loopholes to throw you off your coverage and abandon you alone to your illness; the business model, when they cannot find that loophole, that they will try to interfere with or deny you the care your doctor has ordered; and the business model that, when all else fails, and they cannot avoid you or abandon you or deny you, they stiff the doctor and the hospital and deny and delay their payments for as long as possible—or perhaps tell the hospital to collect from you first, and maybe they will reimburse you.

Good riddance to that business model. We know it all too well. It deserves a stake through its cold and greedy heart, but some of our colleagues here are fighting to the death to keep it alive.

But the biggest reason for these desperate acts by our colleagues is that we are gathering momentum, and we are gathering strength, and we are working toward our goal of passing this legislation. And when we do—when we do—the lying time is over. The American public will see what actually comes to pass when we pass this bill as our new law. The American public will see firsthand the difference between what is and what they were told.

(Mr. FRANKEN assumed the chair.)

Facts, as the Presiding Officer has often said, are stubborn things. It is one thing to propagandize and scare people about the unknown. It is much tougher to propagandize and scare people when they are seeing and feeling and touching something different.

When it turns out there are no death panels, when there is no bureaucrat between you and your doctor, when the ways your health care changes seem like a good deal to you, and a pretty smart idea—when the American public sees the discrepancy between what is and what they were told by the Republicans—there will be a reckoning.

There will come a day of judgment about who was telling the truth. Our colleagues are behaving in this way—unprecedented, malignant, and vindictive—because they are desperate to avoid that day of judgment. Frantic and desperate now and willing to do strange and unprecedented things, willing to do anything—even to throw our troops at war—in the way of that day of reckoning.

If they can cause this bill to fail, the truth will never stand up as a living reproach to the lies that have been told, and on through history our colleagues could claim they defeated a terrible monstrosity. But when the bill passes and this program actually comes to life and it is friendly, when it shelters 33 million Americans, regular American people, in the new security of health insurance, when it growls down the most disgraceful abuses of the insurance industry, when it offers better care, electronic health records, new community health centers, new opportunities to negotiate fair and square in a public market, and when it brings down the deficit and steers Medicare toward a safe harbor—all of which it does—Americans will then know, beyond any capacity of spin or propaganda to dissuade them, that they were lied to. And they will remember. There will come a day of judgment, and our Republican friends know that. That is why they are terrified.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 15 minutes to the Senator from Oregon.

The PRESIDING OFFICER. The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, I thank you, and I thank the chair for his courtesy as well.

At this time of the year, millions of Americans are out in the stores doing their holiday shopping. That is because we Americans enjoy our free markets and our free enterprise system. Whether it is for a holiday or we are shopping for a car or food or a house, we Americans believe we ought to have quality choices in our marketplace, and Americans, our people, ought to be rewarded when they shop wisely.

The American economy works this way for just about everything except health care. Today, American health care is mostly a competition-free zone. Insurance companies enjoy extraordinary privileges as monopolies. Insurers are exempt from the antitrust laws, and in scores of American towns, our people can only get their health care under the heel of just one health insurance company.

Today's health insurance market is essentially dysfunctional, and for most Americans, they have no way to hold the insurance companies accountable. It has been that way since the middle of the last century, since the days of wage and price controls. For literally 60-plus years, American consumers have not been in the position to be able to hold the insurance companies accountable and to get the value for their dollar that they get in every other part of our economy.

Changing this broken health care marketplace is the heart of real health reform. The legislation we will vote on tonight—and, I might add, the chairman of the Finance Committee is on the floor, and this essentially began with his white paper when we started working on it in the Finance Committee—the legislation we are going to vote on tonight, in my view, starts the long march to empowering consumers, to turning the tables on the insurance lobby, and to getting more value for our health care dollar. This can be done through a part of the health reform debate that got some discussion in the Finance Committee and then, because people liked it and didn't know much about it, has since essentially gotten lost in the discussion; that is, the health insurance exchanges.

For folks listening at home today, an exchange is going to be like a farmers market. Various types of health plans are going to be marketed through the exchange, and for the first time—this was an area in which Chairman BAUCUS and I had a great interest in the committee—it is going to be possible for folks to make apples-to-apples comparisons of these various health plans.

There are requirements in the bill that keep the low-quality products out of the exchange. Chairman BAUCUS and I got interested in the need for consumer protection particularly early on in programs, back in the days after Medicare got established when seniors were buying 15 or so private policies to supplement their Medicare and most of them weren't worth the paper they were written on. So with these exchanges as they are designed, that is not going to happen. People are going to get value for their dollar on day one.

There are also some important consumer protection requirements, and I particularly wish to commend the Presiding Officer of the Senate, whose work I have been following. These consumer protection requirements will ensure that now when a consumer pays a dollar in a premium, they are going to get a lot more back in benefits for their dollar. This protection is called a loss ratio. People are going to hear a lot about that concept. It is new, but it essentially means the insurance companies can't walk off with their premium dollar, use it on administrative expenses, use it on salaries, but will instead return it to the public and the consumer in the form of benefits and premiums. I commend the Presiding Officer, the Senator from Minnesota, for ensuring this was all put in place. In my view, these ideas ought to appeal to both Democrats and Republicans—these market-oriented consumer protection principles—simply because they are just common sense.

So should section 10108 of Senator REID's managers' amendment on which the majority leader, Chairman BAUCUS, and I worked very closely. It is entitled ''Free Choice Vouchers.'' This section creates something that has never existed before: a concrete way for middle-income Americans who cannot afford their health care to actually push back against the insurance lobby and force insurance companies to compete for the business of covering those middle-class folks in the insurance exchanges. Unlike today, where if a hard-working, middle-class American can't afford just the one health insurance policy available to him and, thus, is out of luck, with this new provision, there will be a different health care marketplace, with free enterprise choices that can actually drive down costs for the middle class while ensuring those choices are of good quality.

So the big hurdle, it seems to me, in setting up a new health care marketplace, which began with Chairman BAUCUS's white paper in the Senate Finance Committee, is getting these exchanges and getting these vouchers in place.

We are going to be able to build on it. In my view, I think we will have additional opportunities to build on these ideas before the legislation goes to the President. For example, Senator COLLINS, our Republican colleague from Maine, Senator BAYH, and I have written bipartisan legislation that has been endorsed by the influential National Federation of Independent Business and we are working to include that proposal in this legislation. This bipartisan proposal would permit employers who are in the insurance exchange and who voluntarily choose to do so—let me emphasize that this is a matter of a voluntary choice by employers—if they choose to do so, they could give their workers a voucher so that those workers could shop for their coverage. What this means is for millions of employers and employees, the amendment would provide the opportunity to have a choice of American health care plans.

These are unquestionably challenging days for American employers and workers trying to be as competitive as possible in tough global markets. For employers who want more ways to help their workers and the employers' bottom line and for workers who would like more take-home pay and lower health expenses, this bipartisan amendment can be a lifeline. We hope our colleagues of both parties will agree and join our effort, and this can be part of the legislation that ultimately will go to the President.

Let me close with this. My great hope is that long after 24/7 cable TV has moved on to other topics, Democrats and Republicans here in the Senate can figure out a new strategy for

working together, a bipartisan strategy that will let us, together, tap the full potential of real health care reform. That potential is for holding down costs, getting more value for our health care dollar, and, finally, achieving quality, affordable health coverage for all Americans.

I offer this thought because I have long felt both parties have valid views on this topic. I believe our party is absolutely right in saying you cannot fix American health care unless all Americans get good-quality, affordable coverage. If you don't do that, too often uninsured folks will shift their bills to insured folks, there won't be enough prevention, and you won't be in a position to get the most value for the health care dollar.

I continue to believe our colleagues on the other side of the aisle have valid points as well. They make valid points about the role of marketplace forces, the role of competition, the role of choice.

There has to be a way in the days ahead—one of the things that has pleased me is Chairman BAUCUS has said we are going to have a lot of oversight hearings and a lot of work in the days ahead to actually implement this. None of us think we can create a new health care marketplace where there hasn't been one for 70 years in a matter of minutes. So I am very pleased Chairman BAUCUS has indicated we will be doing a lot of the painstaking oversight work in the days ahead to actually implement this transformation in American health care, and I think the chairman knows I will be his partner in those efforts to get this implemented.

So after a year of tough financial hardships, let's find a way to bring to this Senate floor bipartisanship, common sense, and the good will that is public service at its best.

I close by saying that I look forward to working with the chairman of the Finance Committee, who I know shares these views as well.

With that, Mr. President, I yield the floor.

Mr. BAUCUS. Mr. President, I wish to thank the Senator from Oregon for many reasons, one of which is his kind words, which are really appreciated but, much more important than that, his long dedication to health care reform. He even worked for the Gray Panthers way back before he came here. I remember the name RON WYDEN, Gray Panthers, a good number of years ago. Then, lo and behold, both Houses of Congress together—we worked together on reforming Medigap coverage. It was an outrage. Today we talk about medical loss ratios of maybe 80 percent, 85 percent, up to 90 percent, and so forth. I can remember back when it was an outrage, the degree to which Medigap insurance coverage had medical loss ratios of not 80 percent, not 70 percent, not 60 percent; it would be below 50 percent. Insurance companies were selling insurance to seniors trying to cover that gap between what Medicare would and would not cover, and just tragically low, embarrassingly low, outrageously low medical loss ratios.

Senator WYDEN and I got together and got legislation passed to reform the Medigap market—to make Medigap insurance plans more fair. They were ripping seniors off, there was no doubt about it, and we got that changed.

Now, on health care reform, an ardent advocate of more competition, more choice in our health care system—it is clear we need more competition. It is clear we need more choice. On the competition side, in many of our States we find there is only one or two insurance companies that dominate the entire State. That is very true around our country. There is just not the competition there should be.

In addition, there is not the choice. A lot of employees would like to have more choice among insurance companies in their kinds of policies, and so on and so forth. We have a system where most employees are tied to their employer; it is pretty much insurance coverage the employer offers.

If we were starting from scratch maybe 20, 30, 40, 60, maybe 80 years ago, we may not have had such an employer-based system as we have today. Our current Tax Code also tends to encourage excessive insurance coverage because of our employer-based system.

Anyway, I am digressing. Senator WYDEN got us thinking a lot earlier about the problems that caused, and, frankly, I think he is right. I think a lot of Americans think he is right. You can only take things a step at a time here, and we are probably not going nearly as far as the Senator from Oregon wishes to go. But I thank him. He is there, he is dogged, and he works hard on behalf of seniors. He is an advocate of American consumers, respected by health insurance companies, not letting the companies take advantage of citizens. I thank the Senator for that.

I do not see any Senators on the floor on our side. If there were, it would be a good time for them to speak. Pending the arrival of the Democratic Senators, let me say a few things about small business.

Clearly, one of the goals of health care reform is to ensure that employees of small businesses have good, quality, affordable health care options. We all know that is clear. I have talked to small businesspeople.

I will never forget a conversation I had with a logger who has four or five or six people working for him. It was about 2 or 3 years ago. I asked him if he had health insurance. He said, yes, for his family—his wife and himself.

I asked: How about your employees? He said, no; he didn't. You could tell he wanted to, and he wasn't just blowing smoke. He clearly wanted to provide insurance for his employees, but it just pained him because it was too expensive.

We all hear stories like that; they are legion. I can remember talking to another small businessman in my State of Montana, a contractor, who has 5, 6, 8, 10, people working for him. He is just beside himself because the insurance company told him his premiums are going to go up 40 percent next year.

He said: Max, I can't deal with that.

I asked: Why are they going up 40 percent?

He said: Well, they found a preexisting condition with respect to one of my employees. He said: Max, I was beside myself. I can't afford a 40-percent increase. They said it would only be a 20-percent increase if I let him go. But he has been with me 15, 20 years and is one of my best employees. I can't let him go.

He found another carrier and kept his employee. So he did find another insurance carrier, but he had to pay about a 20-percent increase in premiums. He was able to keep his employee, but that is just wrong. It is so hard for small businesses to provide health insurance to their employees. I know it is a trite thing to say, but most jobs in our country are created by small businessmen. That is where most of the jobs are, and it is where most of the creativity is. That is, in many cases, where the greatest need is to help encourage entrepreneurism, American ingenuity, and where a small businessperson can do a good job with the service he is providing.

Last year, 62 percent of small businesses did offer health insurance to their employees. Compare that with other companies that have, say, 200 employees. Among all companies in America that have 200 or more employees, 99 percent of them have offered their employees health insurance. Contrast 62 percent of small businesses offer health insurance and 99 percent of businesses with more than 200 employees offer health insurance.

Among the very small businesses in our country it is lower, lower than 69 percent. Now it is only 49 percent—a very small number of employees—that have health insurance through their small business employer. There are clearly very significant reasons for that. There are barriers that prevent small businesses from finding affordable health insurance options. What are they?

Small businesspeople tell us the main reason—at least one of them—is that the premiums are just too high. I mentioned an example of the contractor I talked with in my State, who said they are going to charge a 40-percent increase in premiums as further evidence that premiums are too high. It is understandable that is one of the main reasons small businesses can't get health insurance.

In the past 10 years, premiums have risen 82 percent for single workers and 93 percent for families employed by small business—virtually doubled premiums in the last 10 years if you are a single person and work for a very small business. That is not true for big business.

As health care costs rise, small businesses are forced to make workers pay a greater portion of these expensive premiums. In 2008, for example, employees at small businesses that did provide health insurance paid more than twice what they paid just 8 years earlier—twice as much.

The low rate of offering and higher cost-sharing responsibilities for employees in small businesses often limit the ability of small businesses to attract and retain employees.

That is why the health care bill before us includes many provisions to make quality coverage for small business more affordable not only for the businesspeople but for their employees. Before the managers' amendment, the bill did include $24 billion in tax credits to help small businesses and charitable organizations purchase health insurance for their employees.

The managers' amendment dedicates additional billions to providing tax credits to small businesses to make health insurance more affordable. The Congressional Budget Office and the Joint Committee on Taxation, which I know is near and dear to the heart of the Presiding Officer—after all, they are an independent arbiter. They can tell us with objectivity what this legislation is or is not—they estimate that the tax credit for small businesses will provide $40 billion in tax relief to small businesses over their first 10 years.

In addition, we start the tax credits a year early; that is, we start them in 2010. In the earlier bill, it was 2011. In the managers' amendment, we start in 2010, right away. This means that in just over a week, after the legislation is passed and signed into law, eligible small businesses will be able to receive tax credits to help them buy health insurance for their employees. This expansion of the tax credits means eligible small businesses will now be able to receive up to 6 years of tax credits. So now starting in 2010, eligible small businesses will receive tax credits worth up to 35 percent of the employer's contribution to employee health insurance plans—35 percent.

Then in 2014, it is even better. Eligible small businesses will receive tax credits worth up to 50 percent of the employer's contribution to employee health insurance plans purchased in health insurance exchanges. The employer would get 50 percent of the cost of the health insurance, that would be available for credit; that is, the employer can credit 50 percent, subtract from his income taxes 50 percent of the cost of insurance.

What do you have to do to qualify? Businesses must cover at least 50 percent of employee premium costs. If you cover half the employee costs, you get to subtract your half from your income taxes. The value tax credit is based on the size of the business and the average wage paid to its employees.

The managers' amendment strengthens the assistance to small businesses by expanding the small business tax credit. In the managers' amendment, the tax credit will be available to small businesses with fewer than 25 employees and less than $50,000 average annual wages. And the full value of the tax credit is now available to small businesses with 10 or fewer employees and $25,000 or less in average annual wages. It moved up from $20,000 to $25,000 so more small businesses can qualify and take advantage of that tax credit. By expanding the wage thresholds, which I just described, more small businesses will be able to claim the tax credits. And tax credits will phase out more slowly as wages increase. This was a high priority for small businesses. We recognized that and responded to it.

The small business tax credit will help make insurance affordable for many small businesses. In 2011, 4.2 million Americans will be covered by quality, affordable health coverage; 4.2 million Americans will be able to take advantage of this. On average, small businesses across the country would receive a new tax credit of about $4,900 to help them purchase insurance. That is per employee, $4,900 to help them purchase insurance for their employees.

The CBO estimates that the small business tax credit will help lower insurance costs by 8 to 11 percent for the employees of small businesses receiving the credit. Let me say that again. CBO estimates that the small business credit will help lower insurance costs by 8 to 11 percent for the employees of small businesses who receive their credit. Without the small business tax credit, many people would have to buy insurance through the exchange on their own without the benefit of a contribution from their employer.

One of the reasons many small businesses are currently unable to afford health insurance is because small businesses lack the buying power larger companies have to negotiate affordable group rates. The Senate bill creates small business insurance exchanges, known as SHOP exchanges, where small businesses can band together and pool their risks, which will enhance their choice and buying power. These State-based exchanges will be a critical tool to help small businesses with fewer than 100 employees shop for health insurance plans and determine their eligibility for tax credits to buy health insurance. Small businesses that prosper and grow beyond 100 employees would be allowed to continue shopping through the exchanges—pooling. The insurance plans sold in SHOP exchanges would be subject to the same transparency requirements and consumer protections, so small businesses can feel confident they are purchasing high-quality plans that will provide quality, affordable coverage for their workers.

The legislation also institutes reforms in the insurance market that will protect individuals and small businesses purchasing plans both inside and outside these SHOP exchanges. These reforms will stop insurance companies from denying coverage based on a person's preexisting health condition or increasing a person's health insurance premiums based on health status or on gender and occupation—a practice that just has to be stopped.

These new regulations are essential to helping small businesses keep health care costs predictable from year to year. That is one of the big problems. Small businesses face this sea of chaos, of volatility, uncertainty, unpredictability in knowing what their insurance costs will or will not be. That is why insurance companies cherry-pick and take advantage for themselves to maximize their profits, but it has the opposite effect on small businesses. This will help, frankly, to buy a lot more certainty that we desperately need.

The changes in the managers' amendment will go the extra step and ensure this bill provides small businesses with the help they so desperately need. Passing health care reform is critical to small businesses. Without reform—this is no small matter; I am not blowing smoke here—without reform, many small businesses will be forced to drop their health insurance coverage they may already have because they can no longer afford it. They cannot afford the increase in premiums. This will leave many employees to fend for themselves in the individual market. We know without this bill passing how unfair the individual market is to people.

Many of the provisions in this bill were designed with small businesses in mind. The bill gives small businesses access to a reformed marketplace where they will have improved buying power to negotiate rates. And the Senate bill provides tax credits to help small businesses buy health insurance for their employees.

Data from CBO tells us that these reforms will make coverage more affordable for millions of small business employees. The small business tax credit will help reduce health care costs for small businesses and their employees. As a result of the larger health reform proposals in the bill, there will be an increase in the percentage of small firms that offer health insurance coverage.

We must act to help small businesses access to quality, affordable health care options for their employees. Too many small businesses around the country are waiting.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. BARRASSO. Mr. President, I just heard my colleague from Montana talk about jobs that are going to be lost, and the jobs are going to be lost if this bill passes.

There was an article in the Wall Street Journal that quoted the Federation of Independent Business, a wonderful organization that works so well with small businesses in this country. Their prediction is that if this passes—if this passes—the mandates in this bill will mandate that employers provide

health care. This is going to cost 1.6 million jobs by 2013.

Then I got an e-mail from a friend in Dubois, WY, who says that if this bill passes, he knows he is going to lay off workers—quite to the contrary of what my colleague from Montana says when he says it is going to help keep people working.

At a time when the country is experiencing 10 percent unemployment, at a time when the people's No. 1 concern is jobs and the economy of this country, we are now embarking on an additional spending spree when our national debt is at the highest levels ever.

I disagree with my colleague from Montana. I think, contrary to what he suggested—he said: I am not just blowing smoke—I believe we will lose jobs if this passes.

Mr. BAUCUS. Will the Senator yield for one brief minute?

Mr. BARRASSO. When I am finished with our comments on this side.

Mr. BAUCUS. I thank the Senator.

Mr. BARRASSO. I also heard the majority whip come to the floor and say the Republicans have only offered four amendments. I offered 19 amendments. So I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up my amendment No. 3148 to protect individuals facing skyrocketing premiums.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Reserving the right to object.

Mr. BARRASSO. The purpose of this amendment is——

Mr. BAUCUS. Reserving the right to object, and I will object, we have been——

Mr. BARRASSO. Regular order.

The PRESIDING OFFICER. Is there objection to the request?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Wyoming.

Mr. BARRASSO. So we have a 383-page amendment brought to the floor, read on the floor yesterday. I worked my way through it, along with my staff—383 pages. And the majority whip comes to the floor and says the Republicans have not offered amendments. I just tried to offer one, unsuccessfully, and it has been objected to.

So I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up amendment No. 3153 to protect young, healthy persons from increased insurance premiums.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, clearly this is a stunt. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BARRASSO. Mr. President, I ask unanimous consent that the pending—and these are—I just heard the comments—these are amendments that are aimed to keep the President's words that we will get insurance premiums under control, people will notice their premiums go down, that we will make it better for people, easier for people. The Democrats ought to accept all these amendments because they are intended to do just that.

I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up amendment No. 3146. This amendment deals with individual mandate penalties and creates personal accounts for young people who are penalized and they have to pay a fee and a fine if they do not obey the individual mandate, and that would go into an account for them so they could use that money to buy their own health insurance.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Reserving the right to object, this is the fourth time today Senators on the other side——

Mr. BARRASSO. Regular order.

Mr. COBURN. Regular order.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BARRASSO. Mr. President, I understand this is going to improve Medicare. I heard the chairman of the Finance Committee say this is going to make Medicare stronger. I believe Medicare patients ought to have the freedom to contract and the right to privately contract for medical services with the physician of their choice.

If, as the chairman of the Finance Committee has now recommended in his statement, it doesn't work out the way it is suggested—I ask unanimous consent that the pending amendment be set aside and I be allowed to call up amendment No. 2984, Medicare patient freedom to contract.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. For the fifth time, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BARRASSO. Mr. President, that is why I am not surprised when I read polls that say negatives abound in polls about this bill, written in secret, brought to us just a little over 24 hours ago with a 383-page amendment, one that is now not going to be allowed to have any amendments offered.

I just offered four different amendments aimed to strengthen the health care system of the country. Each time, the chairman of the Finance Committee is not even interested in hearing what the amendments are about.

The people of Wyoming say: Don't cut my Medicare, don't raise my taxes, don't make things worse for me, especially in these economic times. This is a bill that is going to cut people's Medicare by $500 billion, it is going to raise their taxes, and it is going to make things worse for the people of Wyoming and this country. That is why the front page of a local newspaper has a story, ''Doctor Shortage Will Worsen.'' Great concerns.

Even the Actuary of Medicare and Medicaid says that if all of this goes through—and this is before we had the 383 new pages—if all of this goes through, one in five hospitals is going to have significant problems within the next 10 years and one in five doctors' offices may have to close. That is why this health bill is scary.

For anyone who has not had an opportunity to read Dr. COBURN's, Senator COBURN's article in the Wall Street Journal, an editorial, Thursday, December 17, I recommend the editorial to them. It is titled ''The Health Bill Is Scary.''

I ask unanimous consent to have this editorial printed in the RECORD.

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

[From the Wall Street Journal]

THE HEALTH BILL IS SCARY

(By Tom Coburn)

I recently suggested that seniors will die sooner if Congress actually implements the Medicare cuts in the healthcare bill put forward by Senate Majority Leader Harry Reid. My colleagues who defend the bill—none of whom have practiced medicine—predictably dismissed my concern as a scare tactic. They are wrong. Every American, not just seniors, should know that the rationing provisions in the Reid bill will not only reduce their quality of life, but their life spans as well.

My 25 years as a practicing physician have shown me what happens when government attempts to practice medicine: Doctors respond to government coercion instead of patient cues, and patients die prematurely. Even if the public option is eliminated from the bill, these onerous rationing provisions will remain intact.

For instance, the Reid bill (in sections 3403 and 2021) explicitly empowers Medicare to deny treatment based on cost. An Independent Medicare Advisory Board created by the bill—composed of permanent, unelected and, therefore, unaccountable members—will greatly expand the rationing practices that already occur in the program. Medicare, for example, has limited cancer patients' access to Epogen, a costly but vital drug that stimulates red blood cell production. It has limited the use of virtual, and safer, colonoscopies due to cost concerns. And Medicare refuses medical claims at twice the rate of the largest private insurers.

Section 6301 of the Reid bill creates new comparative effectiveness research (CER) programs. CER panels have been used as rationing commissions in other countries such as the U.K., where 15,000 cancer patients die prematurely every year according to the National Cancer Intelligence Network. CER panels here could effectively dictate coverage options and ration care for plans that participate in the state insurance exchanges created by the bill.

Additionally, the Reid bill depends on the recommendations of the U.S. Preventive Services Task Force in no fewer than 14 places. This task force was responsible for advising women under 50 to not undergo annual mammograms. The administration claims the task force recommendations do not carry the force of law, but the Reid bill itself contradicts them in section 2713. The bill explicitly states, on page 17, that health insurance plans ''shall provide coverage for'' services approved by the task force. This chilling provision represents the government stepping between doctors and patients. When the government asserts the power to provide care, it also asserts the power to deny care.

If the bill expands Medicaid eligibility to 133% of the poverty level, that too will lead to rationing. Because Washington bureaucrats have created a system that underpays doctors, 40% of doctors already restrict access to Medicaid patients, and therefore ration care.

Medicaid demonstrates, tragically in some cases, that access to a government program does not guarantee access to health care. In Maryland, 17,000 Medicaid patients are currently on a waiting list for medical services, and as many as 250 may have died while awaiting care, according to state auditors. Kansas, the home state of Health and Human Services Secretary Kathleen Sebelius, faces a Medicaid backlog of more than 15,000 applicants.

Other unintended consequences of the Reid bill could wreak havoc on patients' lives. What happens, for instance, when savvy consumers commanded to buy insurance realize the penalty is the de facto premium? It won't take long for younger, healthier Americans to realize it's cheaper to pay a $750 tax for coverage instead of, say, $5,000 in annual premiums when coverage can't be denied if you get sick.

OMB Budget Director Peter Orzsag's belief that mandatory health insurance will become a ''cultural norm'' is bureaucratic naivete that will produce skyrocketing premiums and reduced care for everyone. My state's own insurance commissioner, a Democrat, recently confirmed this concern to me in a letter noting that ''the result will be higher insurance rates due to a higher percentage of insured being higher risk/expense individuals.''

But the most fundamental flaw of the Reid bill is best captured by the story of one my patients I'll call Sheila. When Sheila came to me at the age of 33 with a lump in her breast, traditional tests like a mammogram under the standard of care indicated she had a cyst and nothing more. Because I knew her medical history, I wasn't convinced. I aspirated the cyst and discovered she had a highly malignant form of breast cancer. Sheila fought a heroic battle against breast cancer and enjoyed 12 good years with her family before succumbing to the disease.

If I had been practicing under the Reid bill, the government would have likely told me I couldn't have done the test that discovered Sheila's cancer because it wasn't approved under CER. Under the Reid bill, Sheila may have lived another year instead of 12, and her daughters would have missed a decade with their mom.

The bottom line is that under the Reid bill the majority of America's patients might be fine. But some will be like Sheila—patients whose it lives hang in the balance and require the care of a doctor who understands the science and art of medicine, and can make decisions without government interference.

The American people are opposing this bill in greater numbers every day because the facts of the bill—not any tactic—are cause for serious concern.

Mr. BARRASSO. Mr. President, here you have it. We have a bill that is going to be voted on at 1 in the morning on a Monday morning. Why? Because the people who are proposing the bill are scared to let the American people know what is in it. That is why public opinion has soured on this proposal to the point that it is at the lowest level ever, with just 32 percent of Americans in favor, just less than one in three. Less than one in three Americans supports what is being proposed.

I believe each one of my amendments would have raised the level of support, would have made this better for American taxpayers, for American citizens, for American patients, for the patients who depend on our health care system, for the providers who give the care, and for the people who pay for it.

I see my colleague from North Carolina ready to rise. I am so happy to be joined on the Senate floor by these two wonderful colleagues who have a great bill of their own that has gotten very little hearing, very little opportunity, certainly no opportunity for a vote on the Senate floor.

As my Senate colleague from North Carolina gets his microphone ready to go, I will say that to be held to a false deadline of Christmas Day on something as important as a bill that is going to impact the health of every person in this country, impact one-sixth of the economy of the United States—it is much more important that we get it right than that it gets rushed through with speed and secrecy, with not being able to offer amendments when a 383-page amendment by Senator REID is dropped on the table yesterday and a vote is going to be held at 1 in the morning on a Monday morning.

It is astonishing that we do not have bipartisan support, people working together to find solutions. It is astonishing when you have a body such as this of 100 Members, 2 of whom are physicians with 50 years of experience practicing medicine, working with the system, fighting against insurance companies and fighting against the government, two physicians who know that you do not want anybody between you and your physician, you do not want a government bureaucrat, you do not want an insurance bureaucrat, you do not want anyone. But what we are looking at is the worst of all possible worlds.

I ask my colleague from North Carolina if he has some additional thoughts.

Mr. BURR. I do, Mr. President.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I look around this Chamber, and I see the busts of many Vice Presidents who have served as the leaders of this Chamber. It makes me wonder what would they think of the process in which we are currently engaged, individuals who, in a time of history of our country, took so seriously what went on in this Chamber and the effects it had on the American people.

I look at the process we are going through right now and see the way we have trivialized this process—votes in the middle of the night. Twenty-four hours ago, there was not a managers' amendment. There was not a score. Then yesterday morning we got a managers' amendment, 380-some pages, and we got a score. Today we get a notice from the Congressional Budget Office saying that in their score, they made a $½ trillion error, a $500 billion, $½ trillion error in the projection they sent to Congress. In 24 hours, $½ trillion.

Why doesn't this seem to bother those who are the authors of the bill? It is because it is not their money. It is the American people's money. That is the only way you could rationalize how you could be in Washington talking about spending $2.5 trillion at best to stop waste, fraud, and abuse, because, let's face it, Republicans and Democrats agree: There is no health care reform in here. There is a coverage expansion, but there is no health care reform.

Democrats have walked to the floor and said that we lie. I am not lying. Show me the health care reform. Show me where you have drastically changed, transformed health care. If you transform health care, then you wouldn't have to steal $464 billion from Medicare.

Mr. BAUCUS. Will the Senator yield so I can show him?

Mr. BURR. Regular order, Mr. President.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BAUCUS. He doesn't——

The PRESIDING OFFICER. The Senator from North Carolina has the floor.

Mr. BURR. I appreciate that, Mr. President.

We have gone through this, and we are refused the ability to offer amendments. We are refused the opportunity to sit in the back room where the legislation was constructed. It is shared with us when they are ready. But they use everybody's money. Tell me how it is fair to the American people.

When Nebraska gets a sweetheart deal under Medicaid, and Massachusetts and Vermont, in the managers' amendment, when Nebraska is told: We are going to expand Medicaid and we are going to hold you harmless in perpetuity, you will not have to pay, tell me how that is fair to the taxpayers of Virginia, tell me how it is fair to the taxpayers of Ohio, tell me how it is fair to the taxpayers of North Carolina that they are going to pay for what Nebraskans should be obligated to pay. I believe, knowing Nebraska, that the people of Nebraska would want to pay their fair share. But, no, to buy a vote, they have been given a deal.

This bill is still $2.5 trillion. It still steals $464 billion from Medicare. It still puts a tremendous unfunded mandate on every State in this country with the exception of the State of Nebraska. There are a number of States that have a grace period for some period of time, whatever it took to get their comfort level of their vote, but for every other State, at some point they are going to be obligated to pick up that difference.

We cover 31 million Americans who were not covered—that is a wonderful thing—and 15 million of them are dumped into Medicaid, the worst health care delivery system that exists in this country, a health care system that only has the opportunity today to see 60 percent of the available doctors because the other 40 percent will not see them.

Oh, by the way, what did the Chief Actuary of the Centers for Medicare and Medicaid Services say?

The Reid bill is especially likely to result in providers being unwilling—

Unwilling—

to treat Medicare and Medicaid patients, meaning that a significant portion of the increased demand for Medicaid services would be difficult to meet.

The Chief Actuary went on to say:

The CMS actuary noted that the Medicare cuts in the bill could jeopardize Medicare beneficiaries' access to care.

I just heard the Senator from Rhode Island basically come out and say that was a fabricated thing on the part of somebody on this side of the aisle. I am quoting the Chief Actuary, the President's chief health care budgetary person. The Actuary said it ''could jeopardize Medicare beneficiaries' access to care.'' He goes on to say that he finds that roughly 20 percent of all Part A providers—hospitals, nursing homes, et cetera—would become unprofitable within the next 10 years as a result of these cuts. Hospitals will close, nursing homes will close. This isn't fabrication. This is the Chief Actuary of the Centers for Medicare & Medicaid Services, who is part of this administration. The CMS's Actuary found that further reductions in Medicare growth, through the actions of the independent Medicare advisory board—this is the advisory board that is being set up to make determinations about coverage in the future—which advocates have pointed to as a central linchpin to reducing health care spending, may be difficult to achieve in practice.

In other words, we are making claims that aren't right, it is the authors of the bill who are making claims that are not accurate, according to the Chief Actuary.

I yield to the minority leader.

Mr. MCCONNELL. I say to my friend from North Carolina, if that were not bad enough—and it may have been referenced here on the floor before I came out—we have an announcement from the Congressional Budget Office just today. The Senator from North Carolina may have referred to this. On the Director's blog today—the Director of the Congressional Budget Office—is the headline: ''Correction Regarding the Longer-Term Effects of the Manager's Amendment to the Patient Protection and Affordable Care Act.''

CBO has discovered an error in the cost estimate released yesterday—yesterday—related to the long-term budgetary effect of the manager's amendment. They go on to say they were about $½ trillion off in looking at the long-term effects beyond the 10-year window, which further illustrates why we ought not to be rushing this thing through, and we ought to have further opportunity to discover what other problems there are, in addition to the ones the Senator from North Carolina has outlined with regard to special treatment for some States which all the rest of our States have to pay for.

Mr. BURR. The minority leader makes a great point. If we waited another day to vote, we might save another $½ trillion. That is probably in the best interest of the American taxpayer.

I will wrap up, Mr. President, because I know Dr. COBURN wants to speak. Let me say this. I said earlier this still steals $464 billion from Medicare. It also still raises taxes and fees to the tune of $519 billion. Many of those taxes and fees, by the way, are going to impact people well below the $200,000 threshold the President promised he would never touch.

We have just learned in the managers' amendment that we have dropped the doctor fix. They should be comforted in knowing that they have a 2-month extension, but the 1-year extension was dropped in the managers' amendment. Dropped. Why? Because they had to pay for what they were doling out to get extra votes.

I ask unanimous consent at this time, Mr. President, to set aside the pending amendment, and I wish to call up amendment 3134, which is a 3-year doctor fix of the SGR and ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. For the sixth time we are engaged in this stunt, so I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BURR. Well, Mr. President, my hope is no other Member from the other side will come to the floor and say that Republicans haven't come up with substantive amendments to this bill.

Dr. COBURN and I participated in 56½ hours in the HELP Committee. We offered numerous amendments. Some technical amendments were accepted. The amendments that meant anything were rejected along party lines. We have filed a comprehensive health care reform bill—the first one introduced in Congress—in May of this year, I believe. Still, Members from the other side come to the floor and say Republicans haven't offered anything. We were the first. They may not have liked it, but we were the first.

You know what, it doesn't cost this much and it doesn't raise taxes. I think Dr. COBURN will later talk about that bill a little.

I was glad to see that politics comes from all sides. In the managers' amendment we dropped the tax on botox. Hollywood spoke out about this tax on one of their health care tools. And what did we replace it with? We have now put a 10-percent tax on tanning salons. How in the hell does that affect health care? Explain that to me. Are we going to tax everything in this country? I can make a tremendous case that the 10-percent tanning salon tax gets exactly the person that the President said he wasn't going to affect, people who make under $200,000—or are we income testing the tanning tax, too?

Mr. COBURN. Would the Senator yield for a question?

Mr. BURR. I yield to the Senator from Oklahoma.

Mr. COBURN. If we are going to tax tanning salons, why don't we tax anybody who goes to the beach? Because true sunlight is much worse for your skin than a tanning salon. So if the intention was to prevent disease, why wouldn't we tax it where most of the disease occurs? Or how about kids' sports in the summer. Let's tax kids' baseball. Or swimming. Let's tax all the swimming pools because we have exposure to UV light.

This shows the precariousness and the silliness of a large portion of this, and I yield back.

Mr. BURR. The Senator makes a great point, and I am sure we have loaded the chairman of the Finance Committee with additional good ideas he can go back and think on. I am sure before it is over, we will fine parents who don't put suntan lotion on their children—especially if it doesn't meet high enough SPF to block everything the Sun might produce.

This is out of control. This is not the way to write a bill that affects one-sixth of the U.S. economy. I mean it is bad enough it is done behind closed doors, in a back room, with only a few people there, but when the No. 2 Democrat can walk on the floor and say: I haven't seen it, either—well, if the No. 2 Democrat hasn't seen it, how many people were there? How many people had input into this? Was it just Leader REID and Senator NELSON? Was it the Presiding Officer from Minnesota? Nobody knows. Nobody knows. The truth is, and what we do know is that the American people don't like the process, and more importantly the American people don't like the bill.

The chairman of the Finance Committee and others have said: But once it is out there and they get a taste of this, they are going to like it then. Well, let me remind my colleagues: It is too late. The Chief Actuary already told us: Hospitals are going to close, nursing homes are going to close, doctors are going to quit practicing medicine. They will quit seeing Medicare and Medicaid beneficiaries. How do you repair that after you have done the damage? Are we willing to risk that for the future of this country and generations yet to come?

Boy, we have a few hours—8 or 10 hours—before we vote. I hope people get some sense. I hope they pull back from this. Let's leave for Christmas. Let's think about this. Let's go home and talk to people. Let's listen to people in this country. If we do, we might come back, get a new piece of paper, take some of the things in this bill and take some of the things we have talked about on this side of the aisle, take some of the things the American people have talked about, and find a way for 100 percent of the doctors, nurses, and hospitals to survive; find a way for 100 percent of the American people to have coverage, and not the 31 million covered in this bill, leaving 24 million outside the scope of coverage.

You see, when we set out we had three objectives: One was to cover all the American people. We flunked. Another was to invest in prevention, wellness, and chronic disease management. The doctor and I both say we haven't come anywhere close to doing that. The third and most important was to make sure it is fiscally sustainable. CBO, CMS, wherever you want to go, the only way this is fiscally sustainable is if the independent Medicare advisory board continues to cut reimbursements, the scope of coverage, to meet how much we are willing to spend on health care to say it is affordable.

I don't believe that is reform. I believe that is legislation that picks winners and losers, and that is not the role of the Senate of the United States.

I yield to the good doctor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. I want to raise an issue. It was raised in the Finance Committee markup; it was raised in the health care markup. I have behind me the Medicare cuts, and I understand they have been slightly reduced in home health—in the rebuild—but we are going to cut Medicare. We are not going to cut it significantly in the fraud—$2 billion. That is where the real waste is.

The Senator from Rhode Island came down here and said we are trying to scare people, but when we offered the opportunity for the chairman of the committee to prohibit rationing of health care in this country, both the chairman and the Senator from Rhode Island voted against it. It was simple, straightforward, saying no matter what we do in health care, we are not going to do what other countries have done, and that is ration health care. Straight up-and-down votes—party-line votes—against it.

In fact, we are going to ration health care. That is what this bill does. The way we are going to control cost is through the mechanisms outlined in this bill that are going to allow government bureaucrats to decide what you can get treated for, when you can get treated for it, and where you can get treated for it. The rebuttal to that is: In Medicare, it is already illegal for them to ration care, so we don't need a prohibition. The fact is Medicare is rationing right now. They are rationing virtual colonoscopies, they are rationing bone densitometry, they are rationing Epogen, they are rationing Neupogen—two key drugs to maintain survival during the treatment of chemotherapy. They are practicing medicine.

So when given the opportunity to vote and put an absolute prohibition on the rationing of health care, what did the chairman of the Finance Committee do? He voted against that. Because what he recognizes is the ultimate plan. And the answer to Senator BURR's question is: This will collapse. It is not going to be sustainable. The Medicare cuts won't be made by us. We will put it off on a commission and say: Oh, we had to do it, and the result of that will be rationing.

The other result will be what the Senator from Vermont actually wants, which is a single-payer, government-run system. That is why he is intellectually honest. He brought it to the floor and said this is how I think we ought to solve health care. We ought to have the government run it, and we ought to have the government make the decisions. He was honest about it. That is where this bill is going. So if you are a Medicare patient, you should be concerned. If you are a Medicare Advantage patient, you should be concerned.

I have had criticism leveled at me because I do what the chairman of the Finance Committee suggests—I make competitive bidding for Medicare Advantage. But there is a big difference. Mine has no cuts in benefits. They cut benefits 50 percent, in terms of the Medicare Advantage differential.

There are three things you can do to fix health care in this country: You can incentivize prevention and the treatment of chronic disease based on outcome; you can create transparency so that purchasers in the market can actually make a judgment about value and quality; and you can assist those who are on the lower rungs of the economic ladder to get the same kind of care we get. Those are the three things you can do.

I readily admit we don't have a great competitive model in the insurance industry. I want to change that. We had Senator WYDEN come to the floor and say that he loves the free enterprise spirit, yet we want to put an artificial fix in terms of the insurance company, in terms of what you have to have for a return. What if an insurance company came up with 20 percent greater efficiency in terms of outcomes and benefits? They still have to spend that money? In the name of the free enterprise system we are going to kill free enterprise? As a practicing physician, I bristle at the way I run into insurance companies. There is no question about it. We need to fix that.

The point Senator BURR was making is this says it is this way or the highway, when the option we offered—the Patients' Choice Act—cuts taxes, doesn't raise taxes; expands exactly to the level or beyond of this bill and it does at in a faster rate. It extends the life of Medicare. It gives Medicaid patients the same kind of care we get. But it was defeated in committee on a party-line vote. It was filed as an amendment here but not accepted. We had 10 amendments voted on from our side on 2,400 pages of legislation—10 amendments. So it is not about being bipartisan, it is about you have to take this or leave it.

What the American people ought to pray for is that somebody can't make the vote tonight. That is what they should be praying for, so that we can actually get the middle—not me, not mine. I understand I am way over here. But we ought to get the middle of America and the middle of the Senate a bill that can run through this country and actually do what we say we all want to do. There is a large difference of opinion, and it is not rhetoric that is unfounded, as Senator BURR outlined, and as Dr. BARRASSO outlined with an estimate by NFIB of 1.6 million jobs lost. That may be old data, because who knows what the data is now. We haven't had a chance to look at it, because 30 hours after the bill is introduced for cloture and the cloture motion is filed, we are going to vote on it. I am not sure this is a great way to run the country.

What is in the bill? There are zero guarantees that taxpayers won't finance abortion.

There are zero prohibitions on the rationing of health care—zero. There is not one shred of evidence that we are not going to ultimately ration health care under this bill. We are. And the only reason you would vote against a rationing amendment is because you intend to see rationing carried out.

There are zero Senators required to enroll in either Medicaid or a government-run option, either through OPM or Medicaid.

There are now 10 new taxes created. There are 71 new government programs created. There are 1,697 times that the Secretary of HHS is going to write the regulations, and based on CRS calculations there are between 15,000 and 20,000 new Federal employees who are going to be required to carry out this legislation.

There are 3,607 times, before we got the Reid amendment, that the legislation says the word ''shall.'' ''Shall'' is a very important word because the word ''shall'' takes away your options. There is no option when the word ''shall'' is used. The word ''shall'' also says whoever is directing the ''shall'' obviously has more wisdom, more knowledge, more experience than the person the ''shall'' is applied to.

What we have said is, in all our wisdom, in all our many years of practicing medicine and being involved in the care of patients, that 3,607 times we are going to tell the American people what to do.

One of the big ''shall also's'' that I do not think will ever hold scrutiny before the Supreme Court is, you shall buy an insurance policy. That doesn't fit anywhere in the Constitution that I read. If you do the legal research on it, as my staff lawyers from the Judiciary Committee have done, it is highly unlikely that will ever hold up. So the whole premise of a large portion of the taxes collected in this bill will be out the window.

It also will totally change, through adverse selection, all of the insurance premiums in this country because, if you do not have an individual mandate making people buy insurance, the costs relative to the illness and the age, even though we have compressed the ratios, will rise exorbitantly.

There are still going to be 24 million people left without health insurance in this country. There is a $10 billion cost just for the IRS implementation of this bill. There is at least $25 billion in mandates placed on the States, unfunded mandates. Actually it is much higher now. There is $28 billion-plus in new taxes on employers. There is $100 billion, by conservative estimates, in fraud and Medicare and Medicaid a year, and this bill goes after $2 billion over 10 years. So we are going to go after $2 billion out of $1 trillion—not $200 billion, not $20 billion—we are going after $2 billion.

There is $118 billion in cuts to Medicare Advantage but only for those people who do not live in the State of Florida and a couple of other places. If you happen to live in Oklahoma, citizens under the Medicare Advantage are going to lose.

This is now over $500 billion in new taxes on Americans. There is a quarter of a trillion dollars not in this in expense that everybody knows is an expense. We are going to restore the SGR. We are going to fix that. And that quarter of a trillion dollars is based on no increase in physicians over the next 10 years. How many in this body think we are not going to increase the pay of physicians in Medicare under the next 10 years? The assumptions in the CBO report that accompanied the Reid amendment, if you read what they said, they said it is highly unlikely. So that is a quarter of a trillion dollars even though it was not in their numbers.

It also said if, in fact, the cuts came through, which they thought highly unlikely that they would, and if they didn't, then the fiscal numbers associated with the bill are out the window. The final number everybody ought to be paying attention to is $12.1 trillion; $12.1 trillion is what our kids owe outside of owing ourselves—$1.1 trillion. That is going to double in the next 10 years.

Anybody with a lick of common sense who looked at the numbers on this bill would say: Washington, your accounting programs aren't any different from Enron. The same fate of those who created the Enron scam ought to apply to the Congress of the United States. The very fact we are not considering an SGR fix is evidence of that. At least you have to add a quarter of a trillion dollars every 10 years to this bill just to keep doctors even. And don't forget the fact that 34 million new Americans over the next 10 years are going to enter Medicare—are going to enter Medicare.

What are the alternatives? I will not offer other amendments and make the chairman object to them because I know his answer. He calls it a stunt. It is not a stunt when you do not have vigorous amendments offered on the Senate floor. It is not a stunt. The stunt is not allowing amendments to be offered. To allow only 10 of our amendments to be offered on this bill is beneath the dignity of the Senate—on the biggest bill in the last 100 years in this Congress, the only bill in the last 100 years that is going to affect every American in a personal way but also in a fiscal way, a financial way.

There was an amendment to be offered, a conscience protection for physicians. We didn't get a vote on it. Should we force physicians in this country to perform abortions or should we have a vote on whether, if they have a conscience protection, they ought to be exempted from that? Should that not be a part of health care reform? We are not going to get a vote on that.

How about an amendment to reduce the waste, fraud, and abuse in Medicare and Medicaid Programs and protecting Medicare benefits? And increasing the fraud and waste from $2 billion to $100 billion over the next 10 years, that is just 10 percent of what is there. We are not going to get a vote on that. It is not going to be available. The American people are not going to get to hear the debate on that. They are not going to make up their mind. Why? You don't want them to hear the debate on it. If you truly wanted to have a debate on fraud we would have a debate on fraud, and we would have an amendment saying put your stamp down, or are you for the people who are defrauding? Or are you for the status quo? We are for the status quo. We are for the well-connected.

The amendment on rationing that I talked about—or an amendment to limit the bureaucratic increase associated with this bill, which is an amendment I offered, we are not going to get a debate on that. That is a very straightforward amendment. It just says we are not going to increase the number of bureaucrats to implement this bill. We are going to drive efficiency in HHS; that is where this is going to. We are going to say: You can't get a net increase in bureaucrats so get more efficient. Since we are running $1.4 trillion or $1.5 trillion deficits, that is something that everybody else in the country would be doing, but we are not going to do that. We are not going to allow an opportunity for a vote or debate on that. We are not going to have that opportunity.

I have heard the majority mention several times that we didn't have anything to offer. We offered the Patients' Choice Act. CBO said it cut long-term costs on Medicaid, that it saved money on Medicare. They said it saved $1 trillion over the first 10 years for the State and the estimates. Because we couldn't get the commitment that was made to us by the chairman of the HELP Committee that he would score the bill, the bill didn't ever get scored by CBO—but an outside score says it saves at least $70 billion the first 10 years and far in excess of that afterwards. It covers more people than this bill, saves personal choice, doesn't put somebody between you and your doctor.

I heard the Senator from Rhode Island say we were lying about that happening. It is happening today, both from insurance companies and Medicare and Medicaid. So if we really wanted to reform health care we would be attacking that. Instead, we are going to make it worse.

Let me tell you how we are going to make it worse. We are going to use cost comparative effectiveness, which is exactly what the U.S. Task Force on Prevention Services did. They used cost comparative effectiveness, and when they looked at breast cancer, they said it is not cost effective to screen women before the age of 50. You know what. They are right. It is not cost effective. But it certainly is clinically effective, especially if your wife is the one who is 40 and has breast cancer and it was found by a mammogram.

You see, judgment goes out the window. What do we do? We reversed that finding, one of the first things we did as we started the debate.

Are we going to do that every time the U.S. Preventive Services Task Force issues a ruling that is cost effective but not clinically effective? Are we going to do that every time the cost comparative effectiveness panel says: You will do this, and the American people say: That isn't right, the American Cancer Society says: That isn't right. Every time we get one of those rulings will we have to pass a piece of legislation to change it?

The purpose of the three panels is well intended. The Medicare Payment Advisory Commission is well intended. Help us cut costs. But the only way you go for cost is through prevention and management of chronic disease. You are not going to cut costs any other way because 75 percent of everything we spend is on five chronic diseases. So unless you attack the real problem, the real disease, with our health care system, you are not going to solve it.

The lack of art in medicine will become readily apparent in 2015, 2016, and 2017. We will see bureaucratic decisions in between a patient and their provider. That is not a scare tactic. That is absolute fact. We have it now with Medicare. It is there. If I have a woman who is 55 years of age today and I order bone density testing on her and find she has severe osteoporosis, I put her on medicine but am forbidden by Medicare to do the followup exam that is clinically necessary to see if the medicine is working, and not only that, under Medicare rules, she can't even use her own money to buy that test. So 2 years later, we do the test, and we haven't corrected her disease. Now we change medicines to try to find out, but we can't find out again. So she ultimately falls and breaks her hip. There is a 20-percent mortality rate from falling and breaking one's hip. But those are the rules we are operating under now, right now, that you want to expand.

Government isn't ever compassionate. It is never compassionate. People are compassionate. Thought has

to be in the middle of the practice of medicine, not distant thought, near thought. The very fact that an insurance company tells the doctors what they can and cannot do is no worse than what we are getting ready to do with the rest of government-run health care. We didn't fix that problem. We didn't address that problem with this. We didn't guarantee that you could walk with your feet. We said: Here is how much money you can earn, but we didn't address that.

I will give two examples. Two people I have taken care of for over 15 years, both had no clinical indications that they had anything wrong. I contacted the insurance company. I thought they needed an MRI of the brain. Both of them were denied. I got friends who are radiologists to do their MRI. They both had brain tumors. One is still alive. What we are setting up isn't any different than what you have a complaint and gripe about now with the insurance industry. You didn't fix that in this bill. There is no health care reform in this bill. There is health coverage expansion, but there is no reform.

One of those people is still alive, but had we followed either Medicare guidelines, cost comparative effectiveness panel guidelines, which would have forbidden doing an MRI, that one person out of the two would be dead today. So as we sit here and look at our health care system, my biggest worry is, I will be in Medicare. I will get rationed. I know that. The way we are going about it, that is what is going to happen. We are going to ration care. We will not vote to not ration it. You know it is going to be rationed or you would have voted for the amendment in committee that provided a prohibition.

But my real concern is not my generation. My real concern is those who will follow us with $12.1 trillion worth of debt and the fact that every one of those is 25 years of age and younger today. Twenty years from now, they will be responsible for $1 million of both debt and unfunded liabilities for which we will have to collect, on average, $70,000 a year just to pay the interest on what we are sending them. Before they pay the rest of their income taxes, before they pay payroll taxes, before they pay unemployment taxes, before they send their kids to school, before they buy health insurance, before they buy a home, before they buy transportation, the real worry that should be in front of this country, which is the No. 1 issue on the public's mind, is: How do we get out of this financial mess? That is the No. 1 issue on people's minds. It is not health care.

I have no hopes of convincing my colleagues that through 25 years of practicing medicine, dealing with Medicare, dealing with Medicaid, that that is of any value to you. Because we are hell-bent on passing a health care bill and dealing to make sure we can and creating inequities throughout this country and dividing our country.

We heard the Senator from Rhode Island characterize us as liars, birthers, supporters of the Aryan nation. That is what I heard. I sat and listened to it. I think he doth protest too much, for he knows that is not true. There is nobody on our side of the aisle who cares any less than anybody on the other side of the aisle about fixing health care. The rub is, you believe the government is the most powerful thing and the best way to do it. We don't agree with that. We actually believe in the American people. We actually believe in the entrepreneurial spirit of the average American making good decisions for themselves every day, doing things we never do, which is prioritizing where their money is going to go and how they are going to spend it and working like heck to advance the cause of their own family, their own freedom, and their own liberty. You don't believe that because, if you did, you would never put this kind of bill on the floor. This bill limits liberty. This bill says you shall.

Think of the first big step in this bill. In the United States, you no longer have the ability to not buy health insurance. If you have $½ million in the bank and you want to put that at risk and say: I don't want to, you either have to pay a fine, a tax, or you have to buy health insurance. So where is the liberty and where is the commerce clause in that and where does that tie in with individual liberty and individual responsibility? We say: If you don't want to be responsible, then we will make you responsible. We don't say: You have to suffer the consequences of your lack of responsibility.

What built this country was people figuring out if you don't act responsibly, it is going to cost you. We are going to put a block on that and say: You don't have to act responsibly. You don't have to act in your own best economic interest. Don't worry. We will take care of it.

Jefferson warned of that. One of the Founders of this country warned us against doing the very thing we are doing today. If you read the Federalist Papers, you will see what Madison wrote about the welfare clause and the commerce clause. He said, whenever the Senate starts to think about claiming it means something different than it does, here is what we want you to know. It doesn't. It is very limited in scope.

I said yesterday in a press conference that this country is at the point of a crisis of confidence such as we have not seen in hundreds of years. It is true. Whether you are a very liberal individual or a very conservative individual, you don't have any confidence in us. The reason you don't is because we don't act in the country's best interest. We act in our political best interest. Republicans are equally guilty. We look at partisan issues rather than principled issues. What we miss in all that is the best right thing for the country. We are missing it with this bill. We are missing the best right thing for the country.

Mr. CORKER. Will the Senator yield?

Mr. COBURN. I am happy to yield.

Mr. CORKER. I was listening to the Senator from Oklahoma. I know he cares deeply about his patients and continues to treat patients as he serves in the Senate. What he has done is pointed out the fact that there will be much interruption, changes in the physicians' and patients' relationship. But the big picture is what the Senator is concerned about, too; that is, the tremendous indebtedness this country has by the fact that—the good chairman of the Finance Committee is here today listening patiently, and I know this has to be painful to him—half the reform we are talking about is actually putting people in Medicaid, a program that 40 percent of physicians will not see and 50 percent of specialists will not see.

Mr. COBURN. And the outcomes are poor.

Mr. CORKER. Last weekend, the New York Times talked about many physicians prescribing antipsychotic drugs to young people because they don't want to deal with them on Medicaid. So half this reform is people going into this type of program and half the money is coming from Medicare, which is insolvent.

We have spent all this time, all kinds of bipartisan meetings. I know you spoke about the issue of partisanship. I know the good chairman is here. We, early on, said we wanted to join in health care reform. We just didn't want to take money from Medicare, which was an insolvent program, to fund it. What was the major building block of this program? Taking $464 billion from Medicare to fund reform. We were, in essence, blocked out on the front end saying something we thought was the wrong type of principle to build upon.

Mr. COBURN. Mr. President, if, in fact, we got rid of 50 percent of the fraud in Medicare and Medicaid, we would generate $600 billion every 10 years, more than offsetting the cuts that have been outlined in this bill.

Mr. CORKER. So if I understand correctly, of the new patients going into Medicaid, 50 percent of the money comes from an insolvent program. We are not dealing with the doc fix. Much of the savings they have talked about is just like the doc fix that back in 1997, the AMA, both sides of the aisle agreed to do something to save money for Medicare. As the Senator knows now, the Reid amendment takes out all the doc fix, now with a $285 billion gap over the next 10 years to deal with physicians. It is another example of how we don't have the courage. We put in place cuts. We are not going to do that. We know what damage that will cause to patients. In this particular case, we should not do that. But the fact is many of these cuts that have been discussed will never take place. They will never take place. At the end of the day, I come back to the very thing you talked about; that is, we have $12 trillion in debt, $38.6 trillion in unfunded

liabilities for Medicare alone, and here we are passing a bill that is using up the resources we might otherwise use to make it solvent.

Instead of doing that, we are leveraging a whole new entitlement. I heard some of the pundits this morning parroting some of the things I have heard from my friends on the other side of the aisle. Let's pass this bill. We know it is not very good, but we will fix it as we move along.

What I fear is the way we are going to fix it, we are going to fix it by adding tremendous debt on future generations. My guess is over the next very short period—2 or 3 months—the other side of the aisle is going to come right back up here with a huge, several hundred billion dollar unpaid bill to deal with one of these issues we have been talking about. That is the way business is done here.

Mr. COBURN. The Senator raises a good question. How long have we known and how long has Medicare been in trouble that we haven't fixed it? We will not fix it. We will do exactly what the Senator says, what we always do, what we have done since I have been in this body. We put the credit card into the machine and say: Transfer this to your grandkids. We take no pain ourselves. What is lacking in our country today is moral character to lead on the basis of sacrifice. It should start with us as Senators in this body.

Mr. President, I understand our time has expired.

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

Mr. COBURN. Mr. President, I thank the Chair, and I look forward to hearing the remarks in the cloakroom of the chairman of the Finance Committee.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, just a couple, three points here, and I see the Senator from Ohio wishes to speak.

Several times during this afternoon, Senators on the other side of the aisle, in my judgment, put on a little demonstration of trying to offer amendments. They repeatedly asked consent to suspend the normal working of the cloture rule to offer amendments. Earlier, I note for the RECORD, they slow-walked the process when an amendment was in order. They wanted the whole amendment read. And now they are trying to offer amendments, again, to slow down the process. This is clearly a tactic to slow the process. It is not part of the regular order. That is clearly what is going on here. Those were not, despite the protestations to the contrary, serious amendments.

Normally, when a Senator offers a unanimous consent request, they allow the other side to speak briefly on the subject, at least on the reservation of the right to object. That was not allowed here. My colleagues did not allow me that courtesy earlier today, to comment with a reservation of the right to object. So I want to take a moment now to explain what they are really up to. I could not because they would not give me the courtesy to say any words during the reservation. That is why I made that statement.

I heard one Senator from the other side of the aisle complain that the majority is holding tonight's vote at 1 a.m. in the morning on the cloture motion. Let me set the record straight. The majority would be happy to have this vote earlier. We would be happy to have this vote maybe in 10 or 15 minutes from now. We would be happy to have this vote at a decent time. It does not have to be at 1 a.m. tomorrow. It is the other side which is insisting that vote be at 1 a.m. in the morning. So it is they who are insisting on enforcing the letter of the Senate rules. It is their right, but it is also they who are insisting on delay.

I also want to put to bed some of the assertions that they claim this bill does not do real health care reform. Let me mention a few health care reform provisions in this bill.

Mr. President, I do not know if you or any of my colleagues have read this second article in the New Yorker magazine by Atul Gawande. The first article talks about two towns in Texas, basically. The second is basically looking to see whether this bill does reform health care and whether it does cut down health care costs. It is an article I highly recommend to all of my colleagues in a recent issue of the New Yorker magazine.

But, basically, Dr. Gawande concludes this bill includes all of the constructive provisions health care economists, stakeholders, and people who have studied this issue suggest should be part of health care reform. That is his conclusion anyway. I am happy he said that because we worked mightily to make sure we have all the provisions we can here to help constrain health care costs.

What are they? Well, one—although some may disagree with the policy—is an excise tax on high-cost plans, so-called Cadillac plans. It is a bit debatable. Last night I saw a TV ad where a group was advocating passage of this bill: But just not my high-cost plan. Pass the bill, but just not my high-cost plan. I understand the tenor and import of that TV ad, but the main point is, we do have to begin to limit to some degree the excessive cost of some plans, and I think we are very fair and modest here in proposing an excise tax on those high-cost plans. The trick is to set the level at the proper level, not too high, not too low. I think this bill does that.

In addition, all the delivery system reforms this bill enacts with respect to Medicare are so important to improving quality and reducing excess costs. We all know through history that when we reform Medicare and make changes in Medicare, the private sector follows. So the private commercial market will follow whatever Congress does with respect to Medicare; and that is, make good, positive changes. Why? Because Medicare is such a large provider of care, it tends to have a real effect on what other providers do.

What are some of those? Well, basically, we start to change the way we pay doctors and hospitals; that is, we start to pay on the basis of value rather than volume, that is quality rather than quantity. The paradox of that is, when people stop to think about it, we are going to both cut down costs and increase value at the same time because we will be focused on quality. When you focus on quality—not just quantity, not the whole volume of services, but, rather, focus on quality—you are going to get better quality, but your costs are going to go down because you are not reimbursing things such as excessive MRIs, excessive CAT scans, excessive high-cost procedures that do not, in many cases, get to the quality of health care but, rather, are very expensive, and Medicare pays for them. So we are moving more toward reimbursing based on quality and value than quantity.

What else is reform of the health care industry? One is bundled payments and the shared-savings program, which we refer to as accountable care organizations. This allows hospitals and groups to get together to cut down costs. We have bundling in here, which is another idea that moves along the same lines. I might add, too, the CMS Innovation Center and the Independent Payment Advisory Board suggest some of these.

The bill makes it easier for employers to offer workplace wellness programs. We give employers greater flexibility to offer premium discounts for workers who are committed to leading healthier lifestyles. There is a lot of emphasis here on wellness and lifestyles. We give incentives to employers to have wellness programs and preventive programs, which will help, obviously, the worker, but, in addition to that, cut down costs.

There are other provisions here. This bill keeps getting stronger. The so-called freshmen package, led by Senator WARNER, will give the Secretary additional authority to expand delivery system reforms. It expands the scope of the Medicare board to the private sector.

There are many other provisions in here.

The Nation's employers, through the leadership of the BRT, played an important role in developing that package.

And the manager's amendment included a provision that will provide greater access to Medicare data to measure performance.

It is no exaggeration to say that this bill will revolutionize health care.

But don't take my word for it. The 23 economists who wrote to the President agree.

Mr. President, I ask unanimous consent that letter from these economists be printed in the RECORD.

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

STANFORD UNIVERSITY,
CENTER FOR HEALTH POLICY,
Stanford, CA, November 17, 2009.

President BARACK OBAMA,
The White House,
Washington, DC.

DEAR MR. PRESIDENT: On behalf of my colleagues, a group of distinguished economists, I am pleased to transmit this letter regarding essential components of health reform legislation.

Sincerely yours,

Alan M. Garber, M.D., Ph.D.

Henry J. Kaiser, Jr., Professor, Professor of Medicine, Professor of Economics, Health Research and Policy, and of Economics in the Graduate School of Business (courtesy), Director, Center for Primary Care and Outcomes Research and Center for Health Policy Stanford University.

NOVEMBER 17, 2009.

President BARACK OBAMA,
The White House,
Washington, DC.

DEAR MR. PRESIDENT, As the full Senate prepares to debate comprehensive health reform legislation, we write as economists to stress the potential benefits of health reform for our nation's fiscal health, and the importance of those features of the bill that can help keep health care costs under control. Four elements of the legislation are critical: (1) deficit neutrality, (2) an excise tax on high-cost insurance plans, (3) an independent Medicare commission, and (4) delivery system reforms.

Including these four elements in the reform legislation—as the Senate Finance Committee bill does and as we hope the bill brought to the Senate floor will do—will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing. It will help transform the health care system from delivering too much care, to a system that consistently delivers higher-quality, high-value care. The projected increases in federal budget deficits, along with concerns about the value of the health care that Americans receive, make it particularly important to enact fiscally responsible and quality-improving health reform now.

In developing our analysis and recommendation, we received input and suggestions from Administration officials, including the Office of Management and Budget and others, as well as from economists who disagree with the Administration's views.

The four key measures are:

Deficit neutrality. Fiscally responsible health reform requires budget neutrality or deficit reduction over the coming years. The Congressional Budget Office (CBO) must project that the bill be at least deficit neutral over the 10–year budget window, and deficit reducing thereafter. Covering tens of millions of currently uninsured people will increase spending, but the draft health reform legislation contains offsetting savings sufficient to cover those costs and the seeds of further reforms that will lower the growth of spending. Deficit neutrality over the first decade means that, even during the start-up period, the legislation will not add to our deficits. After the first decade, the legislation should reduce deficits.

Excise tax on high-cost insurance plans. The Senate Finance Committee's bill includes an excise tax on high-cost health insurance plans. Like any tax, the excise tax will raise federal revenues, but it has additional advantages for the health care system that are essential. The excise tax will help curtail the growth of private health insurance premiums by creating incentives to limit the costs of plans to a tax-free amount. In addition, as employers and health plans redesign their benefits to reduce health care premiums, cash wages will increase. Analysis of the Senate Finance Committee's proposal suggests that the excise tax on high-cost insurance plans would increase workers' take-home pay by more than $300 billion over the next decade. This provision offers the most promising approach to reducing private-sector health care costs while also giving a much needed raise to the tens of millions of Americans who receive insurance through their employers.

Medicare Commission. Rising Medicare expenditures pose one of the most difficult fiscal challenges facing the federal government. Medicare is technically complex and the benefits it underwrites are of critical importance to tens of millions of seniors and Americans with disabilities. We believe that a commission of medical experts should be empowered to suggest changes in Medicare to improve the quality and value of services. In particular, such a commission should be charged with developing and suggesting to Congress plans to extend the solvency of the Medicare program and improve the quality of care delivered to Medicare beneficiaries. Creating such a commission will make sure that reforming the health care system does not end with this legislation, but continues in future decades, with new efforts to improve quality and contain costs.

Delivery system reforms. Successful reform should improve the care that individual patients receive by rewarding health care professionals for providing better care, not just more care. Studies have shown that hundreds of billions of dollars are spent on care that does nothing to improve health outcomes. This is largely a consequence of the distorted incentives associated with paying for volume rather than quality. Health care reform must take steps to change the way providers care for patients, to reward care that is better coordinated and meets the needs of each patient. In particular, the legislation should include additional funding for research into what tests and treatments work and which ones do not. It must also provide incentives for physicians and hospitals to focus on quality, such as bundled payments and accountable care organizations, as well as penalties for unnecessary readmissions and health-facility acquired infections. Aggressive pilot projects should be rapidly introduced and evaluated, with the best strategies adopted quickly throughout the health care system.

As economists, we believe that it is important to enact health reform, and it is essential that health reform include these four features that will lower health care costs and help reduce deficits over the long term. Reform legislation that embodies these four elements can go a long way toward delivering better health care, and better value, to Americans.

Sincerely,

Dr. Henry Aaron, The Brookings Institution.

Dr. Kenneth Arrow, Stanford University, Nobel Laureate in Economics.

Dr. Alan Auerbach, University of California, Berkeley.

Dr. Katherine Baicker, Harvard University.

Dr. Alan Blinder, Princeton University.

Dr. David Cutler, Harvard University.

Dr. Angus Deaton, Princeton University.

Dr. J. Bradford DeLong, University of California, Berkeley.

Dr. Peter Diamond, Massachusetts Institute of Technology.

Dr. Victor Fuchs, Stanford University.

Dr. Alan Garber, Stanford University.

Dr. Jonathan Gruber, Massachusetts Institute of Technology.

Dr. Mark McClellan, The Brookings Institution.

Dr. Daniel McFadden, University of California, Berkeley, Nobel Laureate in Economics.

Dr. David Meltzer, University of Chicago.

Dr. Joseph Newhouse, Harvard University.

Dr. Uwe Reinhardt, Princeton University.

Dr. Robert Reischauer, The Urban Institute.

Dr. Alice Rivlin, The Brookings Institution.

Dr. Meredith Rosenthal, Harvard University.

Dr. John Shoven, Stanford University.

Dr. Jonathan Skinner, Dartmouth College.

Dr. Laura D'Andrea Tyson, University of California, Berkeley.

Mr. BAUCUS. The CMS Actuary agrees that this bill bends the cost curve. The folks at the Commonwealth Fund say the bill will save families $2,000 per year.

Mr. President, I ask unanimous consent that an excerpt from Dr. Gawande's article from the New Yorker be printed in the RECORD.

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

EXCERPT FROM GAWANDE ARTICLE IN NEW YORKER

There are hundreds of pages of these programs, almost all of which appear in the House bill as well. But the Senate reform package goes a few U.S.D.A.-like steps further. It creates a center to generate innovations in paying for and organizing care. It creates an independent Medicare advisory commission, which would sort through all the pilot results and make recommendations that would automatically take effect unless Congress blocks them. It also takes a decisive step in changing how insurance companies deal with the costs of health care. In the nineteen-eighties, H.M.O.s tried to control costs by directly overruling doctors' recommendations (through requiring pre-authorization and denying payment); the backlash taught them that it was far easier to avoid sicker patients and pass along cost increases to employers. Both the House and the Senate bills prevent insurance companies from excluding patients. But the Senate plan also imposes an excise tax on the most expensive, ''Cadillac'' insurance plans. This pushes private insurers to make the same efforts that public insurers will make to test incentives and programs that encourage clinicians to keep costs down.

Mr. BAUCUS. Mr. President, the Senator from Oklahoma at one point questioned the constitutionality of the mandate to buy health insurance. I might say, we thoroughly studied this issue. I believe there is ample authority for Congress to enact such a provision under the Commerce Clause, and also under the congressional authority to tax and spend for the general welfare provided for in the Constitution.

I might also add, Prof. Mark Hall of Wake Forest University has done an excellent survey article on this subject. Mr. President, I ask unanimous consent that the conclusion of Professor Hall's article, found at www.oneillinstitute.org, be printed in the RECORD.

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

LEGAL SOLUTIONS IN HEALTH REFORM—THE CONSTITUTIONALITY OF MANDATES TO PURCHASE HEALTH INSURANCE

(By Mark A. Hall, JD)

EXECUTIVE SUMMARY

Prepared by the O'Neill Institute

INTRODUCTION

Health insurance mandates have been a component of many recent health care reform proposals. Because a federal requirement that individuals transfer money to a private party is unprecedented, a number of legal issues must be examined. This paper analyzes whether Congress can legislate a health insurance mandate and the potential legal challenges that might arise, given such a mandate. The analysis of legal challenges to health insurance mandates applies to federal individual mandates, but can also apply to a federal mandate requiring employers to purchase health insurance for their employees. There are no Constitutional barriers for Congress to legislate a health insurance mandate as long as the mandate is properly designed and executed, as discussed below. This paper also considers the likelihood of any change in the current judicial approach to these legal questions.

POTENTIAL SOLUTIONS

Congress's Authority to Regulate Commerce: The federal government has the authority to legislate a health insurance mandate under the Commerce Clause of the United States Constitution. A federal mandate to purchase health insurance is well within the breadth of Congress' power to regulate interstate commerce. Congress can avoid legal challenges related to the 10th Amendment and states' rights by preempting state insurance laws and implementing the mandate on a federal level. If Congress wants states to implement a federal mandate, it has the following two options:

Conditional Spending: Congress may condition federal funding, such as that for Medicaid or public health, on state compliance with federal initiatives.

Conditional Preemption: Congress may allow states to opt out of complying with direct federal regulation as long as states implement a similar regulation that meets federal requirements.

Congress's Authority to Tax and Spend for the General Welfare: Congress also has the authority to legislate a health insurance mandate under its Constitutional authority to tax and spend. There are no plausible Tenth Amendment and states' rights issues arising from Congress's taxing and spending power. However, Congress' taxation power cannot be used in a way that burdens a fundamental right recognized in the Constitution's Bill of Rights and judicial interpretations by the U.S. Supreme Court. Since there is no fundamental right to be uninsured, no fundamental rights challenge exists.

Other Relevant Constitutional Rights: Challenges under the First and Fifth Amendments relating to individual rights may arise, but are unlikely to succeed. The federal government should include an exemption on religious grounds to a health insurance mandate as an added measure of protection from legal challenges based on religious freedom. In the alternative, the federal government can simply exempt a federal insurance mandate from existing federal legislation protecting religious freedom.

Considerations: To avoid a heightened level of scrutiny in any judicial review, the federal government should articulate its substantive rationale for mandating health insurance during the legislative process.

LEGAL ISSUES & APPLICABLE LAW

Commerce Clause: Congress has the power to regulate interstate commerce, including local matters that substantially affect interstate commerce. Health care and health insurance both affects and is distributed through interstate commerce, giving Congress the power to legislate an insurance mandate using its Commerce Clause powers.

Taxing and Spending Power: Congress has the power to tax and spend for the general welfare. It can use its taxing power to implement a ''pay or play'' model to tax individuals that did not purchase insurance or provide tax benefits to those that do purchase insurance. Congress can also use its spending powers to influence state action. The taxing power of the federal government can be limited if a tax intentionally and directly burdens the exercise of a fundamental right.

Federalism: The 10th Amendment and principle of state sovereignty in the Constitution prohibit the federal government from commanding the states to implement federal law or policies that would interfere with state sovereignty. This is referred to as the ''anti-commandeering'' principle. A federal employer mandate covering state and local government workers appears consistent with existing Constitutional decisions but still might be susceptible to challenge under the Tenth Amendment.

Individual Rights: The First and Fifth Amendment contain provisions that may have some bearing on a health insurance mandate.

Free Exercise of Religion: The First Amendment's Free Exercise Clause protects the free exercise of religion. In addition, the Religious Freedom Restoration Act (RFRA) prevents the federal government from enacting a law that substantially burdens an individual's exercise of religion, unless the government has a compelling interest.

Due Process and Takings Clauses: The Fifth Amendment includes two relevant provisions. The Due Process Clause guarantees that no person shall be deprived of life, liberty, or property without due process of law. The Takings Clause states that the government may not take an individual's property without just compensation.

CONCLUSION

The Constitution permits Congress to legislate a health insurance mandate. Congress can use its Commerce Clause powers or its taxing and spending powers to create such a mandate. Congress can impose a tax on those that do not purchase insurance, or provide tax benefits to those that do purchase insurance. If Congress would like the states to implement an insurance mandate, it can avoid conflicts with the anti-commandeering principle by either preempting state insurance laws or by conditioning federal funds on state compliance. A federal employer mandate for state and local government workers may be subject to a challenge; however, such a challenge is unlikely to be successful. Individual rights challenges under the First Amendment's Free Exercise Clause or RFRA are unlikely to succeed, although a federal insurance mandate should include a statement that RFRA does not apply or provide for a religious exemption. Fifth Amendment Due Process and Takings Clause challenges are also unlikely to be successful. The legal analysis presented is likely to endure, as the Supreme Court's current position and approach to interpreting relevant constitutional issues appear to be stable.

Mr. BAUCUS. I might also say, Mr. President, the Senator from Oklahoma said the independent Medicare advisory board would ration care. In fact, he even accused us in the Congress—myself included—of voting against a prohibition on rationing. But, I might say, I am not for rationing care in the sense that the Senator from Oklahoma talked about. I do not think anybody in this Congress is. We have to find a system that starts to control costs in a fair way, that increases quality but also cuts costs. That is the underlying premise of the delivery system reforms in this bill. But do not just take my word for it. Right here in the bill, on page 1004, the bill says, with regard to the advisory board:

The proposal shall not include any recommendation to ration health care.

I chuckle a little bit when I say that because the Senator from Oklahoma is very concerned about using the word ''shall.'' If he does not like ''shall,'' then I suppose he means the board would have discretion. But we say ''shall not include any recommendation to ration health care.'' That is on page 1004 of the bill. It is right there in black and white letters. Read the bill. The prohibition against rationing of health care is right there.

Mr. President, I see the Senator from Ohio, who wishes to speak.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I thank the Finance chairman for his leadership.

I have sat here listening. I was watching the debate in the last hour from my office, and then I came over in the last 20 minutes or half hour and watched from here. I am incredulous when I hear my colleagues on the other side of the aisle talk about ''saving Medicare.'' This is the same group of people, with only one exception on the whole Republican side of the aisle, in 2003, who rammed through the Medicare privatization bill that was written by the drug companies and the insurance companies for the drug companies and the insurance companies.

Two things: One, they never paid for it. There was no discussion, no interest, no move to pay for their bill at all. Then they criticize that our bill is costing too much and running up the debt, when the Congressional Budget Office—which everyone knows is fair—they complain about the Congressional Budget Office. It is like at a sporting event. The losing team complains about the ref.

The other side, because they are losing, complains about the Congressional Budget Office. We know it plays fair. We cite it. We must. We do. It helps us move forward and helps us figure things out. But they did not even try to pay for their Medicare privatization bill because the drug companies and the insurance companies would not have gotten their way so much if they tried to pay for it. But the second thing is, their bill shortened the life expectancy of Medicare.

Our bill increases the life expectancy of Medicare for 10 years. And they have the gall to come to the floor and say our bill does not treat Medicare right, that our bill is going to ruin Medicare, that our bill whatever.

If you are a senior citizen in our country, understand what this bill does

for Medicare. This bill guarantees benefits, No. 1. No. 2, this bill lengthens the life of Medicare for several years, as I said. No. 3, this bill helps with the cost of prescription drugs by closing that doughnut hole my friends on the other side of the aisle created back in 2003 with President Bush because the drug companies wanted it that way and the insurance companies wanted it that way.

Last, this bill provides all kinds of services to seniors they were not getting before—mammograms, colonoscopies—for free because we want—not that we want to do a giveaway but we want seniors to be healthy and live longer and have healthier lives. We know that is good for our country. It is good for them. It is good for our families. I am incredulous when I hear them talk about Medicare.

The second thing I am incredulous about when I hear them, that is pretty unbelievable, is how they talk about partisanship. In the Health, Education, Labor, Pensions Committee, which Senator COBURN sits on and Senator BURR sits on—two of the people who were talking earlier—and the Presiding Officer sits on, we accepted 160 amendments. I voted for almost all of them. They made sense. Some were minor; some were more major. That gave this bill a bipartisan flavor to it.

But now they say the bill is too partisan and we were not listening, they say we are rushing it through—whatever they say. But the reason, even with those 160 Republican amendments, they do not want to pass it is twofold. One is people such as Senator DEMINT said: This is the President's Waterloo. If we can defeat this, we can end his presidency. So part of their opposition is strict win-at-any-cost partisanship.

The other reason is, even though there are 160 Republican amendments, on the big questions of the day, it is a philosophical difference. Go back to 1965. Very few Republicans supported Medicare. On the key vote in the House of Representatives, only 10 out of 160 or 170 Republicans supported Medicare. Over here, in those days, there were a few sort of ''Rockefeller Republicans'' who supported it. But, by and large, the mainstream Republican party, at least in Congress, opposed Medicare.

So just like they opposed Medicare because it was a big question, they are opposing this bill because it is a big philosophical question. That is fine they disagree with us, but do not accuse us of partisanship when, one, many of them want President Obama to fail. That is a strategy. It is a political strategy. But, second, do not accuse us of partisanship when 160 Republican amendments were in this bill in my committee, and in Senator BAUCUS's committee many amendments were accepted that were Republican amendments.

Then to say we have to slow this down because it has gone too fast, these negotiations have been going on for months. In the Finance Committee, the Gang of 6 started in mid-June officially, and it began before that.

I want to put a human face on this. When they say, let's not move too fast, do you know why I want to move, why I want to get this done by Christmas? We do not deserve to have Christmas with our families until we finish this. Do you know why? Because every day in my State—in Defiance and in Williwick and in Warren and in Steubenville—every day in my State, 390 Ohioans—lose health insurance.

Do you know what else? One thousand people every single week in this country die because they did not have insurance. So 390 people in my State alone—probably 350 in Michigan; probably 250 in Minnesota—every single day are losing their health insurance, and in this country 1,000 people a week are dying because they do not have health insurance. A woman with breast cancer is 40 percent more likely to die if she is uninsured than if she is insured—40 percent more likely to die if she is uninsured than if she is insured.

So when I see my friends stall and stall, and they have all kinds of reasons—they have the clerk read the bill, they try to talk too long—whatever it is, however they are stalling in so many different ways, they should think about those 390 Ohioans who lose their insurance every day, think about the 1,000 people a week who die because they don't have insurance, and think of the woman with breast cancer without insurance who just has more trouble fighting back.

To further put a human face on this, I wish to share some letters from people in Ohio who have written me. These are people who understand how important it is because it is important to their personal lives, their families, their loved ones, themselves, that we take care of this bill by Christmas.

Sandra from Franklin County writes:

> In December 2008, my partner lost her job. In July of this year she started working part-time in the evening, which didn't offer insurance. In October she found full-time work. We are grateful she is now employed. The job has no coverage. While she was unemployed, it hurt us financially. We are behind on some bills. But we can't afford health insurance for her now. It's a similar story with a friend of mine. He lost his job last year. After looking for a job, he decided to go back to school. He finally found a job and is happy for that. But he also doesn't get insurance.

Maria from Montgomery County writes:

> I work in a school and come in contact daily with struggling families who can't afford basic medical care for their families. Please help. We want an America that sees health care as a right for all.

Today, I was on ''Face the Nation'' with Senator LANDRIEU and Senator ALEXANDER. A woman I was talking to works there part time as a contractor. She has a contracting relationship with them. She helps prepare people before they go on the air. She is not employed by CBS; she is an independent contractor. She has her small business. She has insurance and she pays a whole lot of money for it, and she said: Five years from now, I am going to be on Medicare. I look forward to having the stability and predictability of real health insurance. That is why this is so very important.

Roberta from Greene County down in Xenia, between Dayton and Columbus:

> I am a senior citizen who feels uncomfortable using my fabulous Medicare benefits when others—parents, ill people, the unemployed—don't have any health care at all. Please pass health care reform for all who need and are without medical care.

Roberta, who is on Medicare, knows and understands, No. 1, how important Medicare is to her. She also knows she is going to get more from this bill, including free screenings for mammograms, a free physical every year, and the cost of prescription drugs will be less because we are closing the doughnut hole. She knows this bill—unlike when the Republicans tried to privatize Medicare in 2003—actually lengthens the life of Medicare.

Mr. DURBIN. Mr. President, would the Senator yield for a question? I am going to be speaking at the end of this hour that has been allocated to our side, and I don't want to interrupt the Senator from Ohio but for one reason. I don't know if the Senator from Ohio heard or is aware of a statement made earlier today by our colleague from Oklahoma, Senator COBURN, who came to the floor and said:

> What the American people ought to pray is that somebody can't make the vote tonight. That is what they ought to pray.

I have been trying to reach Senator COBURN because he is on a committee on which I serve and I work with him. This statement troubles me. I am trying to reach him to come back to the floor and explain exactly what he meant about a Senator not being able to make the vote tonight.

I don't know if the Senator from Ohio is familiar with this statement, but I am reaching out to Senator COBURN. I will be on the floor in the next 45 minutes, and I hope he will join me.

I thank the Senator from Ohio for yielding.

Mr. BROWN. I did not see that quote, but I watched what happened here 2 nights ago when we were trying to pass the Defense appropriations bill to make sure our troops were funded in Afghanistan, Iraq, and stateside and in Europe and everywhere else—Korea, everywhere. The Republicans wanted to kill that even though it would mean no funding, it would mean military layoffs, it would mean we wouldn't be able to get the things and supplies we need for the troops, because they said: We want to kill health care reform. I don't understand the desperation—except maybe I do because everything about this debate is protecting the insurance companies. I guess that is more important to them than anything else. So I will be interested too. I appreciate the assistant majority leader's

comments on why Senator COBURN said that.

Let me close with one last letter.

Valerie from Cuyahoga County, which is in northeast Ohio:

I thank the Lord that my husband has a job with health benefits. If he didn't have it, I would be knee deep in medical bills. I know how important insurance is. I could never imagine not being able to go to the doctor. I have had many surgeries and had my fair share of doctors' visits. Could you imagine yourself without medical insurance or not being able to go to the doctor?

She says:

I bet most Senators and Congressmen never had to worry about that. But many Americans have that worry and it is a scary, scary feeling. The time is now to pass health reform.

I know my colleagues have good health insurance. Of course they do. That is a good thing. But I also know many of my colleagues don't spend much time talking to people who don't.

Most people in our—if you are a Congressman or a Senator making $170,000 a year, most people you see and socialize with probably are pretty upscale, probably have insurance. Most of us don't spend nearly enough time—I know the Presiding Officer does this in Duluth and Rochester and all over Minnesota. I know the Senator from Colorado, who worked on a lot of these issues with me in the House, when he goes to Boulder and when he goes home to Denver, he talks to people who don't have insurance.

I just wish more of my colleagues who oppose this bill would meet some of the 390 people in my State or in their States who lose their insurance every day. I wish they would talk to a woman who has breast cancer without insurance, knowing she is more likely to die. I wish they would talk to some of those people whose family members die because they don't have insurance. Because most of us dress like this and most of us hang around with people who dress like this and generally we have good insurance, I think we are a little out of touch. I hope we can pass this bill, go back home, and meet some of these people for whom this is going to matter because I think it will make a difference in how we all look at this.

I thank the Presiding Officer, and I yield the floor.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the Senator from Colorado, Mr. UDALL.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. UDALL of Colorado. Mr. President, I thank the Senator from Montana for yielding. I thank him for his tremendous leadership on this important fight here on the floor of the Senate.

First, I commend my colleagues for strapping on their snow gear. The Presiding Officer comes from the State of Minnesota, where this kind of a storm we have had over the last few days is not that unusual a development. I like a good 16-inch dusting from time to time. We all know what an important issue reforming our health care system is, and braving the elements is a small price to pay.

I have come to the floor a lot over the past few months to discuss the challenges that are facing us as we work toward fixing our broken health care system. One overarching theme I continue to emphasize is just how important this is to putting our economy back on track.

We have a bloated $12 trillion Federal debt which is being fed daily by growing health care costs. Every day, employers, small and large, are laying off workers and slashing benefits for their employees. Great American businesses, especially in our manufacturing sector, have nearly collapsed because of the rising costs of providing health care for their workers.

Those Americans who have coverage lack the peace of mind in knowing that their insurance will be there just when they need it. This lack of stability and peace of mind is a fundamental problem with the status quo today because it takes away one of the things valued most by Americans: their freedom. Today, they are reluctant to move to a new job, to advance their education, or start a small business for fear they won't be able to provide health care for their families.

As we struggle to mend our economy, we can't afford to tell people to stay put. We know from history that encouraging the entrepreneurial spirit of Americans is the key to promoting small business, creating jobs, and driving our economic recovery. Small businesses have accounted for 65 percent of all new jobs created in the past 15 years, but today anyone who owns or has ever tried to start their own business can attest to why rising health care costs is such a major problem in this country.

Take, for example, the story of a gentleman who just recently contacted me from Denver. I will pick up on the theme the Senator from Ohio was touching upon. If we listened to the people in our States, there would be no question that this reform is necessary. Dave is a small business owner. Last year, he saw his insurance premiums skyrocket 27 percent for his employees. When he questioned this unbelievable increase, his insurance company said all he needed to do to save money was just stop offering coverage to his employees. Just let them buy their own insurance, his insurance company told him. When he looked into that, when he checked it out, he found out that nearly half of his workforce would be ineligible for coverage because of preexisting conditions and that those who could obtain coverage were priced out and couldn't even afford it.

I hear this story time and time again—small business owners who want to do the right thing but end up facing annual double-digit increases in their costs. This is so troubling in this economic time because small businesses pay on average 18 percent more than large employers for the same level of coverage.

The status quo—and the Presiding Officer has been articulate and eloquent and involved in this fight—as he knows, is unacceptable, and we can't kick the can down the road any longer. The good news is the legislation we are considering contains essential provisions aimed at helping small businesses, individuals, and American families across our country. Let me touch on a few of the important provisions that are in this final package.

Health insurers will be organized into well-regulated marketplaces and finally forced to compete. This would then involve a creation of a more transparent process for individuals and small businesses, so, for the first time, you can actually compare insurance plans side by side.

The legislation helps individuals pay for these newfound health insurance options. More than half of the cost of reform goes to financing tax credits to put money back in the pockets of middle-class families to help them purchase a health plan. As Chairman BAUCUS has pointed out, these tax credits represent the biggest tax cut since 2001.

In addition, starting in 2010, many small businesses will also qualify for new tax credits worth up to 50 percent of the cost of providing health insurance to their employees.

Also in this bill—I can't emphasize this enough—Americans will no longer go bankrupt because of health care costs. We are the only developed country in the world where citizens go bankrupt because they have health care costs they can't afford.

Insurers will be prohibited from denying access to health care because of preexisting conditions, limiting coverage because of age or gender, or dropping the insurance someone has already paid for simply because they get sick.

Regardless of what we hear from our friends on the other side of the aisle, this legislation saves money, it strengthens Medicare, it reduces the deficit, and it puts us on a path to finally addressing our growing national debt. In fact, noted MIT economist Jon Gruber estimates this bill will save small businesses 25 percent, or about $65 billion per year, on health insurance. That translates into $30 billion in take-home pay and an estimated 80,000 saved jobs.

While the bill before us makes important improvements, I would also like to say a few words about the package of amendments offered by the distinguished majority leader. I took some time, as I think we all did over the last snowy 24 hours, to familiarize myself with the changes, and I wish to touch on some of the most promising revisions that have been made.

I wish to first note my appreciation for including the freshman package. These amendments were offered by myself and the freshman class, of which the Presiding Officer is a member, and

they have attracted bipartisan support. They boast the endorsements of business, labor, and consumer groups. The provisions inject more cost containment in the bill, cut down on regulatory and bureaucratic redtape, and push even more aggressively toward a reformed health care system.

I am particularly pleased to see a provision I worked on that would expand the scope of a new board designed to strengthen Medicare. The amendment would task this board not only to monitor Medicare but to look for ways to improve the entire health care system as a whole. I believe the independent payment advisory board is one of the best cost-containment tools in the bill, and I want to acknowledge Senator ROCKEFELLER for his work in developing the idea, as well as Leader REID for putting even more bite into the authority of this important panel of experts.

Second, I wish to express how proud I am that Majority Leader REID put so much emphasis in the managers' amendment on improving health care in rural America. The difficulty of accessing health care in rural communities is a unique struggle I have been increasingly concerned about, especially as I have traveled around Colorado's rural areas in the past several months. I am glad to see the inclusion of an amendment I authored to establish a rural physician pipeline training program designed to help bolster our rural health care workforce. Many of my colleagues joined me in offering this important amendment which has the potential to recruit and train more doctors to practice in rural areas.

In addition, I also authored an amendment that would establish an explicitly rural element to the community transformation grant program which is aimed at helping prevent and reduce chronic disease in communities across the country.

My amendment would ensure that rural areas are getting their share of this critical prevention and wellness funding, and I was very proud to see this important change included as well.

As I begin to close, I wish to say that although this bill has been strengthened significantly by the majority leader's efforts, it is not perfect. But I do not think anyone expects Congress to craft a perfect piece of legislation. We could never send the President a bill that fixes all the problems in our health care system or exactly reflects the priorities of every single Member of Congress, including myself. But what I am confident of is, this legislation can establish a sturdy foundation upon which we will build, improve, and strengthen access to health care in America.

Will there be mistakes made along the way? I do not doubt it. But as a lifelong mountain climber, I know from experience that the stumbles you experience along the way are a necessary part of reaching any mountaintop. Providing insurance and quality care for all our citizens is a once-in-a-lifetime opportunity to improve the health and well-being of every American. These are the goals of our health insurance reform and, over the next few days, I look forward to passing a bill which modernizes our health care delivery system, increases much needed choice and competition in the health insurance industry, and helps put our economy back on track, while improving the financial security of middle-class working families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the senior Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Mr. LEVIN. Mr. President, first, let me thank the Senator from Montana for the extraordinary work he has put in on this bill for so long, so many months, so many years. Thanks also go, of course, to the Democratic leader, our majority leader; Senator DODD; and others who have worked so hard to get us here.

We are in a pivotal moment in the long fight to reform our health care system. Everyone should, by now, be well aware of the history—how Presidents of both parties have tried and failed to achieve reform and how, after months of painstaking review, we have arrived at this instant, closer than ever to health care reform.

It would be impossible to fashion legislation on an issue so massive and so complex on which all could agree in every detail. Those seeking perfection will have to look outside this Chamber or, for that matter, in any piece of complex legislation.

But when they look outside the walls of this Capitol, Senators will also find problems that dwarf the imperfections in this bill. They will find a broken health care system, one in which we pay vastly more than other wealthy nations for care that is, in many cases, demonstrably inferior. They will find Americans struggling to afford the health care coverage they have and employers struggling to provide insurance to their employees. They will find manufacturers struggling under a costly health care burden, from which their international competitors were long ago freed. They will find employee and employer alike plagued by never-ending uncertainty about the cost and availability of health insurance, an instability that haunts families and hinders job creation. They will find costs rising so fast they threaten to swallow the rest of the Federal budget and sink family budgets. They will find astonishing amounts of money spent, not on better care or innovative treatments but on overhead and bureaucracy. They will find millions of Americans with no coverage at all—a tragedy for the uninsured and a source of inefficiency and expense that make health care more expensive for all of us.

So the choice before us now is whether any imperfections we might see in this bill outweigh the mountain of evidence that our current system is in dire need of repair. It is between moving forward on a significant repair of a broken system or quashing yet another attempt to reform health care in surrender to the status quo and to the rhetoric of distortion and fear.

To me, this choice is clear: We cannot wait any longer for health care reform. The people of my State cannot wait. The people of this Nation cannot wait. Now is the time for all those years of frustrated effort, all the research and analysis, all the debate and discussion, for us to reform a broken system. We must vote for cloture on the managers' amendment before us and continue to vote for cloture on the endless filibusters that confront us because we cannot wait.

We cannot wait any longer to reform this system because its costs are out of control. In 1990, this Nation, 12.3 percent of its gross domestic product on health care. That is $1 in $8. By 2018, the Centers for Medicare and Medicaid Services, CMS, estimates that figure will increase to 20 percent, and $1 in every $5 will go to health care. CMS estimates that after spending about $6,000 per capita on health care in 2003, we will spend more than $13,000 per capita in 2018, more than doubling our per-person expenditures in 15 years.

This translates directly into unsustainable costs for the American people. According to the Kaiser Family Foundation, thousands fewer of our businesses are offering insurance than a decade ago, a clear sign they can no longer sustain cost increases of 6 percent or more, year after year. If we do nothing, these costs will continue to rise at a rate which will swallow the budgets of families, businesses, and government.

We cannot wait any longer because, even for those fortunate enough to have insurance where they work, they are increasingly unsure it will be there when they need it most. Every Member of this body has heard from constituents who thought they had solid health insurance, only to find out their insurer had wriggled out of paying for desperately needed care or found a convenient preexisting condition that voided their coverage or capped their coverage, so they faced a crushing choice between treatments they had to have and costs they could not afford. Even in cases where families have health insurance, medical emergencies can leave debilitating costs in their wake. According to a study in the American Journal of Medicine, 62 percent of all bankruptcies filed in the United States in 2007 involved medical costs; and even more compelling, three-quarters of those bankruptcies involved people who had health insurance when they got sick. There can be no more clear sign of the need to act than the fact that having health insurance is no insurance against bankruptcy from medical costs.

We cannot wait any longer because so much of the enormous cost at the heart of this health care crisis is money spent on that having little or nothing to do with quality care. For example, for those who purchase insurance in the individual market, roughly 30 percent of the costs they pay will stem from the insurance company's administrative expenses—on bureaucracy, not medicine. A 2003 study published in the New England Journal of Medicine found that, in 1999, Americans spent over $1,000 per capita on health care administration costs—more than $1,000 for every man, woman, and child in this Nation spent on paperwork and redtape. Electronic medical records, which make administration more efficient and improve the quality of care, are still not in use for most patients.

Finally, we cannot wait any longer because the inefficiencies of our system are crushing us and our budgets and, even more pointedly, because so many lives are at stake. One hundred forty thousand Americans have lost their lives since 2000 because they lacked health insurance. We cannot afford to walk down this road any longer. We must change direction. This bill will do it in a positive way.

An analysis by the Urban Institute, using methodology developed by the Institute of Medicine, determined that since 2000, nearly 140,000 Americans have lost their lives because they lacked health insurance. Other studies show that breast cancer patients, stroke victims and other patients are, as common sense suggests, far more likely to die from their conditions if they lack adequate health insurance. These are rigorous studies that bring us to an inescapable conclusion: If we fail to act, Americans will continue to lose their lives when they need not, simply because they don't have adequate health insurance, or any health insurance at all.

For these reasons and many others, it is long past time to reform our system. The question we must then answer is, will we come closer to a health care system worthy of this Nation if we pass this bill?

I believe we will. The legislation before us will reform the insurance system in powerful ways, protecting patients from the host of abuses they now so often face. We will begin to control spiraling costs in many ways, and establish research centers to find new ways to improve care and lower costs. We will create powerful incentives to reduce administrative burdens and costs. And we will bring millions of Americans into the health care system, reducing the number of uninsured, and reducing what is both a burden of inefficiency on the system and a moral blemish on our Nation.

We are out of time and out of excuses. Now we must choose. Choose between beginning to reform on the one hand and continuing the status quo on the other. Our individual problems with this bill cannot be allowed to overshadow the much larger problems with our health care system. Near the end of this long path toward health care reform, we cannot turn back. The Senate needs to move forward.

Again, I thank my good friend from Montana and the other leaders who have made it possible for us to get to this point.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from Montana is recognized.

Mr. BAUCUS. I yield 10 minutes to the Senator from Illinois.

Mr. DURBIN. Mr. President, I thank my colleague. I wish to renew my invitation to Senator COBURN to please come to the floor but do it soon before my time expires. I called his office to make sure he knew I was trying to reach him. I have spoken on the floor to alert the Republican side that I wished to ask him to explain a statement he made on the floor earlier today. The statement of Senator COBURN of Oklahoma said:

> What the American people ought to pray is that somebody can't make the vote tonight. That's what they ought to pray.

I am troubled by this statement. I want to give the Senator from Oklahoma an opportunity to explain it because the simple reality is, I don't think we should be wishing misfortune on any of our Senate colleagues on either side of the aisle. I don't know if this was an innocent statement or something he now wants to clarify. But as stated, it troubles me.

It troubles me because I am afraid it reflects the situation we find ourselves in too often in the Senate, where people are literally invoking God's name in prayer for political purposes—in this case, to wish misfortune on one of our colleagues who would not be able to make our 1 a.m. scheduled rollcall. I do not wish misfortune on any of our colleagues.

Mr. BAUCUS. Will my colleague yield on that point?

Mr. DURBIN. I am happy to yield.

Mr. BAUCUS. I wish to ask my colleague, who knows the Senate procedures so very well, why are we having a 1 a.m. vote? Isn't it possible it could be a different time?

Mr. DURBIN. I thank the Senator because he is exactly right. Under the usual business of the Senate, we agree that we will do something more thoughtful and humane and a vote at an earlier time. Senator REID has approached Senator MCCONNELL and said we have one of our Senators, Senator BYRD of West Virginia, with significant health problems, who was been brought to the floor now early in the morning, late at night, and in a wheelchair. He looks better than ever, I might add. He is being asked to show up at 1 in the morning because we could not reach what is usual comity and gentlemanly accord on scheduling a vote.

It is unfortunate because now we face this 1 a.m. vote and with no cooperation on the other side to even change the vote for a very humane reason.

Mr. BAUCUS. The requests on this side for a vote at a reasonable hour—now it is 10 after 5 say maybe 5, 6, 7, 8 eight clock—a reasonable time, instead of 1 a.m., have been rejected by the other side?

Mr. DURBIN. Unfortunately, the Senator from Montana is correct. What the Senator from Oklahoma says is:

> What the American people ought to pray is that somebody can't make the vote tonight. That's what they ought to pray.

I do not think it is appropriate to be invoking prayer to wish misfortune on a colleague. I want him to clarify that. I have invited him. I tried to reach out to him. He is my friend and I have worked with him. But this statement goes too far.

The simple reality is this. We are becoming more coarse and more divided. It is understandable we would disagree on political issues. That happens all the time. But, unfortunately, we have allowed that political disagreement to spill over into our personal relationships and friendships and that does hurt this institution.

We rely on one another on both sides of the aisle so much. I would say from the start that Senator REID has offered the Republican side of the aisle accommodations and asked we try to do things that might help the families and individuals in the Senate, and we have not had any luck to date.

Hope springs eternal. I hope Senator COBURN can make it to the floor to explain his statement. Earlier this week, there was a prayercast involving several Senators—I did not hear it; I only heard references to it—where they were actually in a group praying for the defeat of this legislation on health care reform. It is their right to do that.

I can recall as a high school football player saying a prayer my team would win a football game. I don't know if God had any time to worry about my little football game. But when it reaches a point where we are praying, asking people to pray that Senators won't be able to answer a rollcall, I think it has crossed the line. I hope my friend and colleague from Oklahoma will come and explain exactly what he meant.

I wish the bill before us were different. I wish it had a strong public option. I wish it offered Medicare to people 55 years and older. I wish it eliminated the McCarran-Ferguson antitrust exemption for health insurance companies. Unfortunately, it does not do those things.

My disappointment over those elements should not lead me to conclude this bill is wanting or bad. The opposite is true. We have to look to the positive side of what this legislation will do.

This health care reform will extend the reach of health insurance coverage to 30 million more Americans. I see on the floor this evening my colleague from Arizona. He and I were on a television show early this morning. I am sure we got great ratings because the

public can't wait to hear us, but during the course of that television show, the Senator from Arizona expressed concern that 20 million Americans would not be covered by our bill.

Interesting, isn't it? Today 50 million Americans are not insured; 50 million Americans are uninsured. This bill will provide insurance for 30 million more, meaning 94 percent of Americans will have coverage, the highest percentage in the history of our country. The Senator from Arizona says it does not go far enough to include more people.

We have waited patiently now for 21 days during the course of this debate on health care reform for the Republican plan for reforming health care. It has never been produced. Promised but never produced. I think the reason is obvious. It does not exist. Several times they have said on the floor: We have a plan, and they will wave a bill at us. When the Republicans had a chance over a 3-week period of time to offer their substitute, they never did. In fact, in over 20 days of active debate on the floor, there were exactly four Republican amendments on health care reform. Four in 20 days, 1 every 5 days. At that rate, how long would the Republicans have us stay on the floor waiting for the next amendment?

That is the reality. They offered six motions to stop the debate, remove the bill from the floor, and send it back to committee. Of course, when it came to actual substantive amendments changing sections of the bill, they would not do it. So the Republicans have come up empty. They are running on empty when it comes to health care reform which means this task of writing a bill is either beyond their pay grade or beyond their will and they like the system as it exists.

I do not. Fifty million uninsured Americans is unacceptable in this country. I think we have to reach a point where we move forward with 30 million now and then find ways to bring in the additional 20 million. Remember, when Social Security was enacted into law, with the resistance of the Republicans—they resisted it saying it is too much government—the safety net extended to widows. We extended in years that followed Social Security protection to dependents, survivors, and the disabled and we added a cost-of-living adjustment.

It was not the end of Social Security in the 1930s. In the years that followed, we built on the original bill and we will build on this original model of health care reform. The same thing is true under Medicare. Medicare as originally offered did not cover disabled people. It did not provide home health care, therapy, or prescription drugs. Over the years, we added those benefits.

I believe this is an important starting point. I also think it is important we provide insurance protection for Americans. When it comes right down to it, too many people are denied the therapies, the surgeries, the medications their doctors recommend because some clerk in an office at a health insurance company is instructed to just say no, and they say no repeatedly.

We also make sure that patients are first, even with our additional amendment guaranteeing the right of people to pick their doctor and keep their doctor. It is a patient-first approach that we are using on this bill.

We hold the health insurance companies accountable and say if they turn around and gouge the patients before they want to be part of the insurance exchange, they can be disqualified. We saw what happened with credit card reform. When the banks had their way after the passage of credit card reform and during the period before it went into law, they ran up the interest rates on credit cards. I got letters in the mail from American Express and others saying: Incidentally, because of the new Federal law, we are going to raise your interest rate on your credit card over 20 percent. We know some of these merchants, given enough time, will capitalize on that time and try to exploit that system. Our bill is going to go after them.

The medical loss ratio is an important part in the bill. I am sure the health insurance companies are not going to be happy with it. It says: Stop taking those premium dollars and turning them into administrative expenses, advertising, bonuses for CEOs' high-paid salaries. Take the money and pay for medical services for the people you insure. If you do not, if you take too much of this money for profiteering, you are going to have to rebate it to your customers. It is changing the balance, giving customers a chance when it comes to health insurance—something that is long overdue.

We extend the health care safety net in this bill. Mr. President, 1.8 million people in my home State of Illinois will have access to affordable health insurance. I have met them. They are hard-working people, small businesses, part-time employees, unemployed people—none of them has health insurance. Again, 1.8 million in my State of almost 13 million are going to have the chance to be covered.

We will have 10,000 more community health centers.

I cannot tell you what an exciting idea this is. If you visit a community health center in Arizona or Illinois, you know what I am talking about. This is a clinic in a neighborhood, usually, or small town where people can literally walk through the front door and get access to primary care physicians who will help them through their medical difficulties. They do not have to wait until they are so bad they end up in an emergency room where costs are dramatically higher. They have a doctor, a nurse, a medical professional, a dentist right there in their community. We estimate this bill will add 10,000 more community health clinics across the United States. That is going to be a dramatic change.

It also will create the opportunity for 20,000 more primary care physicians across America. If there is anything more we need, it is family care, internists who can deal with the medical needs of people before they are referred to a specialist or before their situation has deteriorated.

This bill is going to provide for all people under 133 percent of poverty—that is about $29,000 for a family of four—the security of knowing they are under Medicaid protection without health insurance costs, without health insurance premiums. We will say to those working poor people: You are going to have health insurance. We also believe that progress is going to take some time.

I recall that Senator Teddy Kennedy, who I wish were here for this great battle for which he prepared for four decades, said in his book ''True Compass'' toward the end that real reform is never over. It is not. This is a beginning. It is an important beginning. It establishes important principles.

I say to the critics, we don't expect every aspect of this bill to work perfectly. It is an imperfect product made by mere humans trying to do their best. But some of the things in this bill are going to dramatically change health care in America for the better. We are going to find ways to deliver quality care to people in a cost-effective way. We are going to change parts of our system today which, unfortunately, under this current system are out of control. The costs are out of control.

Moving coverage to an additional 30 million people, 94 percent of Americans under coverage, something no other bill from either side of the aisle has proposed, reducing our deficit—incidentally, we now have a CBO statement which makes it clear that the budget savings in the second 10 years—the first 10 years is $130 billion; the second 10 years is up to $1.3 trillion. They qualified it, but it still is the most dramatic deficit reduction bill in the history of the United States. There has never been a bill that has come before us that reduces our deficit so dramatically.

It reduces it because it works. It brings down the cost of health care. As far as Medicare is concerned, this bill will add at least 9 years of life to Medicare. Medicare, which is going to face serious financial problems in about 7 or 8 years, has a new lease on life with this bill of 9 or 10 years.

To say this saves Medicare and puts it on sound footing is a fact that has been confirmed by the Congressional Budget Office, all the speeches on the floor notwithstanding.

This bill is also going to move us forward in the whole area of looking at ways to deal with medical negligence and medical malpractice. We provide incentives and grants to States to find ways, without penalizing the true victims of medical malpractice, to reduce the incidence of lawsuits, to reduce defensive medicine. That is a conscientious and thoughtful way to approach this.

I would say, if I were to ask anyone to offer a prayer—and I don't do that very often—I would say a prayer for the 50 million uninsured Americans, folks who go to bed without peace of mind that they have health insurance for themselves and their families. I would say a prayer for those turned down by health insurance companies when their doctor says they need a certain therapy or a certain medication or a certain surgery. Those are the people I think of. I pray good fortune for them. I do not pray for misfortune for anyone in the Senate—not for any of my colleagues, not for any of my political opponents. I do not think that is appropriate use of prayer to do that.

I am sorry, as I bring this to an end, that the Senator from Oklahoma has not been able to come to the floor. I have tried now on several occasions through the cloakroom and other ways to invite him to come and explain his remarks. I am troubled when he says the American people ought to pray that somebody can't make the vote tonight. I pray for everybody. I don't pray for misfortune for anyone in the Senate. Let's have the vote. Let's have all 100 Senators here voting their conscience, voting their heart.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I will be a bit presumptuous here that I can speak for most Senators and probably most of the American people. One thing in life that is so difficult to deal with is when you are working with somebody, irrespective of a situation, and trying to resolve an issue, a problem, and the person you are talking to or working with is not dealing in good faith. When each side is dealing in good faith, then each side will begin to recognize the merits of the other person's point of view and each person tends to recognize the deficiencies and faults of his own point of view. It is a good-faith exchange.

Not very many things in life are black and white and not many issues are black and white. Most of them are some shade of gray. I may think that even though my issues—I am not white and the other guy is black, I like to think my shade of gray is more light than his shade of gray. That is not relevant. What works is when both sides talk to each other and try to make an accommodation.

I think I can safely say most Americans think our health care system needs some repair. It is too costly. There are too many cases when the insurance industry cherry-picks and takes advantage of people. It is not the right thing to do.

Also, we have to find a different way to pay for doctors and hospitals, reimbursing on basic quality, not quantity. Almost all doctors agree we should move in that direction.

A few minutes earlier, one Senator got up and said CBO has made this huge error, a $½ trillion error. He goes on and on about this $½ trillion error. To be honest, if we are going to deal in good faith, we should mention the pluses and the minuses, and let the Senators and the public figure out where all this nets out.

CBO has made many statements, most of which I think the Democratic side has relied on, and CBO has made statements that the Republican side has relied on. It is not black and white. It is a shade of gray.

In this case, it is true that CBO sent a letter, I think it was today—in fact, I have it here with me—that said they made a $½ trillion error in the second 10 years. What was the error? I don't remember the exact figure, but essentially I think CBO said this legislation will reduce the debt in the last 10 years by I think it was ½ percent of GDP which comes out to about $1.3 trillion to the good. It reduces the debt by $1.3 trillion.

CBO in a letter to us came back and said they made a mistake. This legislation does reduce the Federal budget deficits over the subsequent 10 years but not by as much. A ½ percent GDP should have been between a ¼ percent GDP and ½ percent GDP.

Half the story is CBO said they made an error of ½ percent GDP. But the full story is, still, nevertheless, the Congressional Budget Office says:

> All told, CBO expects that the legislation, if enacted, would reduce federal budget deficits over the decade over 2019 relative to those projected under current law—with the total effect during that decade that is in a broad range between one-quarter and one-half percent of GDP.

Essentially, they are saying: We made a mistake at CBO, but still this is going to reduce deficits between $615 billion and, say, $1.3 trillion. That is the full story.

I hope when we debate here that we give both sides of the story. That way we can work more toward common ground what is right. Nobody is totally right. Each of us is here serving in good faith. We want to do what is best for our people in our home States, and we are trying. Different States have different points of view. We are going to get better solutions in health care reform if we talk to each other in good faith and give the whole story, not just part of it.

The PRESIDING OFFICER. The Republican whip.

Mr. KYL. Mr. President, I appreciate the comments my colleague from Montana made. I think the point my colleague earlier was trying to make was that we just got the bill yesterday and have not gotten a full CBO or final CBO score; that the correction simply revealed the fact there is a lot there to digest, and we ought to have more time to understand exactly how the interrelated pieces of the bill work, how all the CBO scoring relates, and so on. When CBO can make about a $600 billion error, as I understand, that is a big error. So there is probably more and a lot we don't understand. It would be helpful if we had more time to understand this and how it all works, and that was the point my colleague was making, I believe.

But I do appreciate my colleague pointing out it is better we work in good faith and, for the most part, I certainly recall the long conversations the ranking Republican, Senator GRASSLEY, and the chairman of the committee had. I know they worked in good faith, and it would be best if we did that. It is to that end I wish to speak to some comments a colleague made earlier today.

I don't know whether it is frustration or maybe just the lens through which partisans view things and their opponents, unfortunately, that spawned the remarks earlier today from one of our Democratic colleagues, but in either event, his characterization of his Republican colleagues, I think, requires response.

He began by talking about the malignant and vindictive passions that have descended on the Senate. Here is what he said, and I am quoting:

> . . . too many colleagues are embarked on a desperate, ''no holds barred'' mission of propaganda, obstruction and fear. History cautions us of the excesses to which these malignant, vindictive passions can ultimately lead. Tumbrils have rolled through taunting crowds, broken glass has sparkled in darkened streets, strange fruit has hung from southern trees.

I couldn't believe my ears, these references to Kristallnacht, one of the first and most vicious attacks on the Jews by the Nazis, and hanging of Blacks. The majority leader's remarks last week, comparing the Republicans' position on health care to the proslavery movement, remain largely ignored as the clumsy, offhand remarks of a partisan, but the references earlier today appeared not to be off-the-cuff mistakes but prepared text, deliberately delivered by one of the brighter minds of the Senate.

Our colleague went on to acknowledge, and I quote again:

> . . . that in the heat of those vindictive passions, some people earnestly believed they were justified. Such is the human capacity for intoxication by those malignant and vindictive political passions.

Well, yes, Republican Senators do believe our position is justified—in fact, correct. There are honorable people on both sides of the aisle who obviously have to agree to disagree. But our colleague attributes no good motive to Republicans, whose passions are simply ''malignant and vindictive.'' He adduces evidence to support his claim. First, an unnamed editor of the Manchester Inquirer who wrote that the GOP ''has gone crazy'' and an unnamed economist who believes our party has been taken over by the ''irrational right.'' A Philadelphia columnist talked about ''lunacy on the Republican right.''

Further quoting now: '' . . . it has gone crazy, is more and more dominated by the lunatic fringe and has poisoned itself with hate.''

I wonder if my colleagues believe our position is animated by hatred. Why else would we oppose this legislation? Well, he answers that question too. It is because, he says, first of all:

. . . to break the momentum of our new young President. They are desperate to break this President. They have ardent supporters who are nearly hysterical at the very election of President Barack Obama—the birthers, the fanatics, the people running around in right-wing militias and Aryan support groups. It is unbearable to them that President Barack Obama should exist. That is one powerful reason. It is not the only one.

Well, talk about vindictive passions. Does my colleague believe that is why I oppose the legislation—or my colleague JOHN MCCAIN? I hate to disappoint some folks, but I don't care about the political fortunes of the President, at least not right now. I may about 3 years from now. I don't like this bill. That is why I oppose it.

My colleague says there is another reason. He says it is the ''insurance industry,'' which he proceeded to demonize. I am not one to defend the insurance industry, but it is strange to see it so demonized by my colleague, whose party brags of getting another 30 million people insured by what? The insurance industry. Why subject these folks to such awful torture? But the real irony is, the legislation which we oppose, the insurance industry supported. It made a deal with the Obama administration and key Senate Democrats: You mandate that every American has to buy one of our policies, and we will support your bill. There was a deal all right, but it was between the insurance industry and key Democrats. The insurance industry obviously didn't dictate the Republican position, which largely opposes the individual mandate.

Well, finally, our colleague also accused Republicans of engaging in something else. He said we were engaged in a:

. . . campaign of falsehood about death panels and cuts to Medicare benefits and benefits for illegal aliens and bureaucrats to be parachuted in between you and your doctor.

He went on to state:

Our colleagues terrify the public with this parade of imagined horrors. They whip up concerns and anxiety . . . then they tell us the public is concerned about the bill.

So the reason the public is opposed to the bill is because of the power of Republican Senators to terrify our constituents about imagined horrors. Let us look at the examples given.

I don't know of any Republican Senator who has characterized the health care rationing as coming from death panels. I heard that phrase in another context. We have tried to discuss the provisions of the bill we believe do result in rationing. The chairman of the committee and I have had a lot of debate on this subject. I wish Senator ROBERTS and I could offer a couple of the amendments we wanted to offer to make sure there is no rationing in the bill. I think it is a real problem and should be debated on its merits.

The benefits for illegal aliens, I suspect he was referring there to the House debate, but it is still the case that there are completely inadequate provisions in the bill to verify eligibility for benefits. You can even apply by telephone, so just about anybody could apply for some of the benefits.

Third, the matter of Medicare benefits. I don't think we are terrorizing our constituents about Medicare benefits, unless they understand the facts, and the facts are that Medicare benefits are going to be cut. The Congressional Budget Office says the Medicare Advantage benefits are going to be reduced from a monthly actuarial value of $135 down to $49 a month. That is CBO saying there is going to be reduction in the benefits for those who have the private Medicare Advantage policies. That includes dental, vision, hearing, vision care, fitness, and a variety of other programs.

We have had a semantic debate in this Chamber between those who say: Well, the fundamental benefits of the Medicare law are not specifically eliminated or reduced in the legislative language of the bill. That is true. But what is also true is, the additional benefits in Medicare Advantage are being reduced. That is unassailable. It is also true—and CMS, for example, refers to this—that enrollment is going to be reduced because of these reductions in benefits. They talk about the lower benchmarks, and they say when it is fully phased in, enrollment in Medicare Advantage plans would decrease by about 33 percent. So this is not some kind of fantasy. This is taken from the Congressional Budget Office and from the CMS Actuary.

Finally, in addition to the Medicare Advantage, the Actuary says simulations by the Office of the Actuary suggest that roughly 20 percent of party providers; that is, hospitals, nursing homes, home health care, would be unprofitable within the 10-year projection period as a result of productivity adjustments. That means they would go out of business. Obviously, senior care is going to be affected by this legislation, and we believe negatively so. That is an honest debate to have, and it is one which we would like to have.

But, finally, my colleague turned the world upside down by arguing the only reason we are here the week before Christmas is because of Republican bad behavior; that we ruined the holidays for the professional staff because we followed the procedures of the Senate that require the reading of the bill.

It is true that requirement is usually waived, but then we usually have plenty of time to know what is in a bill. Usually, a bill works its way through committee and both parties know what is in it. We both help to write the bill. It is transparent. It is usually printed long before it comes to the Senate floor so we know what is in it. The reason it was read was so our staff would, in fact, have time to read it, to advise us—because we didn't all have time to read it ourselves—and to advise the public, our constituents, of what is in it. Again, we received it yesterday and we are voting on it tonight. That is very little time to know everything that is in there.

The more we learn about what is in there, the angrier a lot of people get. The special deals for one State, for example, are simply wrong. That is why you take time to see what is in it. The majority of the public, according to opinion polls, want us to take more time to understand what is in this bill.

A final point on this. I have to say, the majority leader dictates the schedule of the Senate. All Senators are pretty much equal, but the majority leader has two things he can do and only he can do. He has the right of first recognition, and he has the right to set the schedule. By the schedule, I mean when he files a cloture motion, which is what brings this bill to the floor or this amendment to the floor. When he files the cloture motion, that is what determines when the vote will be. He determines when to bring the Senate back in session. Under the rules, an hour after he brings us back in session, the cloture motion ripens and we have a vote.

He can set that time at any time. He can say tomorrow morning, at 9 a.m., the Senate will come back in session and we will vote at 10 a.m. The leader could do that. That is his right, and he is the only one who has the right to do that. But instead, he says we will come in at 1 minute past midnight tonight. Therefore, the vote will be 1 minute past 1 a.m. tomorrow morning. It is his right to do that.

We didn't do that; he did that. He is the only one who has the right to set that schedule. If he wanted to set a schedule that was a little more convenient for all the Members—including our dear friend, the Senator from West Virginia, who is ill and indeed does have to get out of a bed to come in a wheelchair to this Chamber—the majority leader has it within his power to say we will do it at a more convenient time.

Why would he do it in this way? Because he has deliberately decided—and all majority leaders have not done quite this but have done similar things—to set a recess and then work us up against the recess so we will have an incentive to finish. It is usually a pretty good incentive. Certainly, going home for Christmas is a big incentive. So the majority leader figures, if he can schedule this bill and the various votes in such a way that we end up voting on it on Christmas Eve, that maybe then we will hurry up and try to do it because, as one Democratic staffer is quoted as saying: ''We need to hurry up and pass this bill because the longer it hangs around the harder it will be''—meaning to pass it. That is true. The more the public finds out about it, the less they like it.

So the majority leader is trying to get it done as quickly as he can, and ''as quickly as he can'' means scheduling us for a vote 1 hour after we come

in. Since there has to be an intervening day—and today is the intervening day—tonight, at 1 minute after midnight, we will reconvene for the next day and then have the vote at 1 a.m. It is purely the majority leader's decision to do it that way. Republicans have nothing to do with it.

If I had my way, we would vote at 10 o'clock in the morning. But that is not the way it is going to be. So please don't say it is Republican bad behavior that results in having to vote on this bill late at night. The process is determined by the majority leader.

I guess I am going to conclude by saying I don't believe this bill can be sold on its merits, and I think that is another reason why we have to hurry up and do it—before the public figures out what is in it. The public opposes this bill not for the reasons imagined by my colleague but because it will cut Medicare benefits, it will increase insurance premiums—not cause them to go down—it will raise taxes, put the government in charge of too much, it will cost trillions of dollars, and it will result in the delay and denial of care. That is why the majority of Americans want us to start over and address the problems on a step-by-step basis.

I was amused by my counterpart, the Democratic whip, saying Republicans have only offered four amendments. I think it was seven but say it is four. Guess who determines how many amendments we get to offer? The majority leader. He sets that schedule as well. He says now it is our turn to offer an amendment. Then it is your turn. The way he managed the schedule, we only got to file either four or seven amendments. We have 200 amendments pending. We would love to get as many of these pending and voted on as possible. Believe me, it is not Republicans who don't want to vote on our amendments. The majority leader, again, has set the schedule.

This is why we oppose the bill. It is why we don't like the process. We respect what our constituents are telling us. We believe this bill will be bad for them, and it will be bad for our country. Our Democratic colleagues have a different position. Neither their position nor ours is malignant, nor should they be expressed vindictively.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, we have all been waiting for many weeks while the Democratic leadership worked behind closed doors, out of public view, to write this new health care reform bill, and this process, of course, is very much contrary to what the President promised during the campaign—that negotiations on the health care reform bill would even be on C–SPAN so everybody in the country could see it. So now a very secretly put together bill is out for our consideration with just a few days to consider it.

Last week, they were considering expanding Medicare to people between 55 and 64 years of age—also, increasing Medicare to cover people up to 150 percent of poverty—and thirdly, having a government-run plan run by the Office of Personnel Management.

Now we have something entirely different. We have the Reid amendment, and it is chock full of special deals. It does nothing to fix the fatal flaws in the 2,074-page bill we started with, and now we have a bill that is probably 400 pages longer than 2,074 pages.

What kind of changes does this new amendment make to the original Reid amendment? Well, one tax disappears—it was a tax on cosmetic surgery—and in its place we have a new tax, a tax on tanning bed services. The dial on the Medicare payroll tax is turned up. So the first-time marriage penalty in a Medicare tax—one that hits about half the two-earner couples—is enhanced. Well over 1 million couples get to look forward to that tax hit—can you believe it?—just for being married. So the old marriage penalty is back. The dial on the insurance fee is also turned up in the back end of the bill.

But with respect to a few favored insurance companies, the fee is turned off. The very limited small business tax credit is expanded—over $½ trillion in new taxes, according to the official congressional scorekeepers. What kind of tax changes stay the same? Basically, the managers' amendment in the underlying Reid amendment still imposes new taxes—new taxes on everything from tanning beds to insurance companies to wages to heart valves to drugs and even more.

Contrary to what has been said on the Senate floor this very day, the tax burden still rests on many middle-class folks. As has been said, there is a sizable subsidy that 12 million tax-filing families and individuals receive. We do not dispute that. But what the other side does not want to acknowledge is this: There are 42 million tax-filing, middle-class families and individuals who will pay higher taxes under this 2,000-plus page bill. For every middle-class, tax-filing family who receives an insurance subsidy, three middle-class families will pay higher taxes.

I ask unanimous consent to have printed in the RECORD a copy of a corrected version of an article from Congressional Daily, dated December 18, of this year.

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

[From CongressDaily AM, Dec. 18, 2009]

LABOR CITES JCT ANALYSIS TO ARGUE AGAINST CADILLAC TAX

(By Peter Cohn)

Labor officials Thursday unveiled new ammunition in their fight against a proposal to tax high-cost health insurance plans in the Senate health bill, citing a congressional analysis that found more than 22 million households earning less than $200,000 would see a tax increase by 2019.

That figure could rise a bit as the Joint Committee on Taxation did not distribute information on tax returns for married couples earning up to $250,000, which is the threshold set by President Obama when he pledged not to tax the middle class. The tax issue could be the most intractable difference between Senate and House-passed legislation—which instead relies on a millionaires' surtax—as Democratic leaders struggle to cobble together a bill that can pass in both chambers next year. Communications Workers of America President Larry Cohen, whose group released the JCT figures, said they demonstrate ''irrefutably that the excise tax—which will result in reduced coverage and increased costs for our middle class families—is the opposite of reform.''

Most House Democrats and union officials are adamant that the final version does not break Obama's pledge and tax those households earning less than $250,000. Obama at one point appeared to endorse the House bill's surtax, which is the single-biggest revenue source in either bill at $460.5 billion. There are major problems with that tax in the Senate, however, not least because it is not indexed for inflation. It also could affect about one-third of all income earned by small business owners that file individual tax returns, according to JCT.

''This is going to be a major problem, no question about it,'' said a senior Democratic aide. ''The White House is going to have to weigh in and provide some direction.''

There have been some mixed signals. The president in a July press conference said the House surtax ''meets my principle'' of not burdening ''families who are already having a tough time.'' In a speech to Congress after Labor Day, however, Obama endorsed the Senate excise tax as a ''modest change that could help hold down the cost of health care for all of us in the long run.''

The 40 percent excise tax in the Senate bill would affect employer-sponsored coverage worth more than $8,500 for single workers and $23,000 for family plans beginning in 2013. Those figures would rise with inflation, plus 1 percent each year, with higher beginning thresholds for older workers and those in high-risk professions. Certain high-cost states would be granted additional room before the tax kicks in.

In a White House blog post Wednesday, National Economic Council Deputy Director Jason Furman said the Senate bill would not hike taxes on the middle class and actually would provide a net tax cut.

He noted JCT estimates that only 3 percent of health premiums would be affected in 2013, a figure that rises to 8 percent by 2019, as well as the higher wages that would accompany a decrease in costly health benefits.

One school of thought holds that whatever bill is able to muster 60 Senate votes will form the basis for the final legislation, and House Speaker Pelosi will have to deliver the votes in her chamber. Another says 188 House Democrats that oppose the Senate tax—a broad cross-section led by second-term Rep. Joe Courtney of Connecticut, who requested the new JCT data, and Rep. Sander Levin of Michigan—won't allow the House to be steamrolled.

''How did they get into this mess?'' one labor official asked. ''They've set this thing up terribly, and they have a huge problem in their Caucus.''

The senior Democratic aide said another Senate provision, an increase in the Medicare payroll tax for those earning above the $200,000 and $250,000 thresholds, could meet the House test. Another idea, promoted by Sen. Debbie Stabenow, D-Mich., would apply the Medicare tax to unearned income such as capital gains and dividends and also has some cache in the House.

But those proposals also have the disadvantage of being prime revenue sources to

help shore up Medicare's finances over the long haul, which could be negated if used up to help expand healthcare benefits to younger workers.

House moderates at one point considered a plan authored by the centrist Democratic think tank Third Way to tax ''excess medical inflation,'' or healthcare premiums that are rising much faster than overall economic growth. Sen. Thomas Carper, D-Del., an honorary Third Way co-chairman, has pitched the idea in his chamber as well. He continues to argue it could be a fallback position; other sources on and off Capitol Hill suggested the train has already left the station and it was too late to inject a new and untested idea into the mix.

What is striking is the amount of agreement between unions and Republicans on the Senate's excise tax, however. Republicans, including Sen. John McCain, R-Ariz., have long held that taxing employer-provided health coverage is the best way to keep costs down and raise revenues. But in opposing the overall health bill, they have latched on to the fact that the excise tax and other taxes in the bill would hit those middle-class workers Obama wants to protect.

According to JCT data analyzed by Senate Finance Committee Republicans, the number of households earning less than $200,000 that would be hit with a tax increase number closer to 42 million in 2019, or about 25 percent of all tax filers under that threshold.

They looked not only at the excise tax but also a scaled-back itemized deduction for medical expenses for those with costs not covered by insurance, and those affected by the Medicare tax that have losses bringing their income under the thresholds.

The numbers factor in those who receive premium tax credits and subsidies to offset the cost of buying health coverage in the bill. Most of those hit with net tax increases earn between $50,000 and $200,000 annually. Of those households earning under $75,000, roughly 12 million would come out ahead, JCT found, including many who earn too little to pay taxes.

Mr. GRASSLEY. This new compromise does not fix any of the core problems in this original 2,074-page Reid bill. It is still that long of a bill. It is still a $2.5 trillion massive bill as far as costs are concerned. The Reid amendment actually adds 400 more pages.

These closed-door negotiations did not produce a better product. Quite the opposite. It still taxes middle-class families, seniors, and veterans. Millions of people still will not be able to keep what they have, as the President promised in the last campaign. A lot of people who were hoping to pay less as a result of the word ''reform'' will still end up paying more.

I am not just talking about the young and the healthy. It still imposes higher premiums for prescription drug coverage on seniors and the disabled. It still permanently cuts all annual Medicare provider payment updates based on productivity gains outside of health care. These cuts still go into effect, even if it means providers will get a negative payment update, and these permanent cuts still threaten Medicare access to care.

The bill still cuts $120 billion from Medicare Advantage, cuts that will reduce Medicare benefits for 11 million beneficiaries, contrary to what the President told us in his speech in September—that nobody is going to get cut in Medicare. This bill still creates a new body of unelected officials with broad authority to make further cuts in Medicare beyond the $40-some billion that are in this bill.

This bill still unwisely makes the board permanent. This bill still requires this board to continue making even more cuts in Medicare and to do that forever into the future.

The damage this group of unelected people could do to Medicare is unknown, but we certainly do know how impossible it will be to undo any damage that unelected board does, if Congress decides we ought to undo it. That is because whatever cuts they make we have to offset, and stirring up that money is very difficult for offsets.

This bill passes a $26 billion unfunded mandate on to the States because the Reid amendment even made this problem worse by adding $1 billion to that unfunded mandate for States under Medicaid. These increased costs will cause States to raise taxes, maybe cut education, maybe cut transportation, and maybe cut law enforcement. But it is still money the States have to dig up.

This bill still has the CLASS Act in it, even though the administration's own Health and Human Services Chief Actuary says it runs the risk—a great risk—of being unsustainable.

It still has a special carve-out for committee and leadership staff from having to use the health insurance exchanges. This is a cute move on the part of somebody in these closed-door offices. I got an amendment through the Senate Finance Committee on a unanimous basis that, if the people of this country have to use the exchange, employees and Congressmen on Capitol Hill ought to use it. But, no; when you get to the secrecy behind doors, just the Congressmen and their permanent staffs but not the thousands of people who serve on leadership staff or committee staff, they still got the deal they have today. So they are not going to know what the American people are going through by using the exchange.

This bill still has special deals for brand-name drug makers that will reduce access to generic drugs, making drug costs even higher for everyone. What this process has shown is that there is a clear and significant philosophical difference between this side of the aisle versus that side of the aisle. Those differences are still there, and the lines between us on this specific piece of legislation become brighter still, even though maybe on 90 percent of the legislation going before this body, there is bipartisan cooperation. But on this one, restructuring one-sixth of the economy, health care being a life-or-death issue for 306 million Americans, this is different from anything this body has tried before. On something such as this, maybe there is a legitimate reason for having differences.

Republicans tried to reduce the overall cost. They said no. They increased the spending in the bill. Republicans tried to reduce the pervasive role of government. They said no, and they increased the role of government. Republicans tried to make it harder for illegal immigrants to get benefits. They said no, and that still has not been fixed. Republicans tried to guarantee that Federal funding for abortions would not be allowed under this bill. That has been the Federal policy since 1976. That has even had bipartisan support ever since the Hyde amendment was put in place that year. But they said no. They wouldn't agree to apply that policy. That still has not been fixed. Republicans tried to allow alternatives to the individual mandate and the harsh penalties associated with it. They said no. They have subjected even more people to the mandate, and they have raised penalties. Republicans tried to raise medical malpractice reform. They said no. Real lawsuit reform is still not in this bill.

We have watched while the other side has expanded government coverage. Since this process began, the other side has been working hard to move millions of people from private coverage to government-subsidized coverage. The bill creates new government programs that cover families making close to $100,000 a year. When we hear about that in rural America, in the Midwest part of the United States, they think we have gone bananas in this body by subsidizing families making $100,000.

At the end of the day, after raising billions in new taxes, cutting about $½ trillion from Medicare, imposing stiff new penalties for people who don't buy insurance and increasing costs for those who do, still 23 million people will not have health insurance. I don't think this is what the American people had in mind when we promised to fix health care.

The Reid bill imposes a $2.5 trillion tab on Americans. It kills jobs with taxes and fees that go into effect 4 years before the benefits of the bill take hold. It kills jobs with that employer mandate. It imposes $½ trillion in higher taxes on premiums, on medical devices, on prescription drugs, and yet more. It jeopardizes access to care with massive Medicare cuts. It imposes higher costs. It raises premiums. It bends the cost curve in the wrong way because people would expect you to bend inflation down, but this bill takes it up. This is not what people have in mind when they think about health care reform.

We have been hearing repeatedly from the majority whip from Illinois that the Republican side has offered only four amendments. I found this to be rather astonishing. The majority whip should know, because they are filed at the desk, that Republicans have put forth 214 amendments. In addition to striking some of the bad ideas in the Reid bill, these amendments also contain Republican proposals that are

improvements over the Reid bill. But in this rush to get it done, the majority has decided they don't want to consider any more of the 440 amendments filed at the desk.

Let's be clear. We keep them so people can have access to them anytime they want to, the 440 amendments that have been filed, that we are accused of not offering any suggestions or improvements. Right here in these three binders, any one of the amendments you want, it is there.

Since this happens to be the case, I would like to take them up on their interest in considering additional amendments. The majority leader and my friend, the Senator from Montana, have both said they want this bill to fill the doughnut hole in the Medicare Part D Program. I share my colleagues' desire to provide even more protection than seniors get under Medicare. I filed an amendment that is in this binder, amendment No. 3182, that would use the savings from medical liability reform, which happens to be about the second or third thing that always comes up at my town meetings that the people in this country feel we ought to be working on if we are going to make real the word ''reform.'' It would put that $50 billion into savings toward eliminating the doughnut hole. The amendment puts the needs of 27 million seniors ahead of the needs of trial lawyers. I can't speak for my colleagues, but that seems like a pretty easy decision.

To my good friend from Montana, I only have one unanimous consent request. I ask unanimous consent to set aside the pending amendment in order to offer amendment No. 3182, which is at the desk.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, reserving the right to object, the doughnut hole will be filled. I have made that promise. Senator REID has made that promise. The White House made that promise. When the bill is presented on the President's desk, the doughnut hole will be filled but not in the way suggested by my friend from Iowa. He is one of my best friends in the Senate, and it is with regret that I must object.

The PRESIDING OFFICER. Objection is heard.

Mr. GRASSLEY. I find it disappointing that we would miss the opportunity to forgo $50 billion in savings that could make prescription drugs more affordable for 27 million seniors. Even though my friend has just said they are filling the doughnut hole, I would quickly say it is being filled in a way that the big pharmaceutical companies are going to make sure they are selling prescription drugs, prescribed drugs, for a long period of time and not have the savings that ought to come from using generics to a greater extent. This $50 billion—actually $54 billion—that CBO says we would save with medical malpractice reform would be a better way of filling that doughnut hole.

I have a parliamentary inquiry of the Chair.

The PRESIDING OFFICER. The Senator will state his inquiry.

Mr. GRASSLEY. I want to make a parliamentary inquiry about the pending managers' amendment. My inquiry will be whether the pending amendment, which everyone agrees is critical to the health care reform legislation before us, complies with Senate rule XLIV.

Senate rule XLIV was adopted as part of major ethics and government reform legislation. It was passed in 2007. Its title was the ''Honest Leadership and Open Government Act.'' The Democratic leadership made it the first bill introduced when they took over the majority in 2007. It enjoyed broad bipartisan support. I wish the reform had been tougher. The part of the legislation that became Senate rule XLIV dealt with the transparency of earmarks. They are technically defined as ''limited tax benefits'' and ''congressionally directed spending items.''

Rule XLIV applies to floor amendments such as the pending managers' amendment. Rule XLIV requires the sponsor of the amendment—in this case, Senator REID—to provide a list of these narrow provisions. Senator REID has not provided the list. We received the several-hundred-page amendment yesterday morning. Republican staff have performed a preliminary review. That review finds that some items might—I repeat, might—be limited tax benefits. There are press reports about narrowly crafted exceptions to the insurance fee.

I ask unanimous consent to have printed in the RECORD a copy of the Dow Jones article dated December 19, 2009.

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

[From Dow Jones Newswires]

SENATOR NELSON WINS TAX CARVE-OUT FOR MUTUAL OF OMAHA IN HEALTH BILL

(By Martin Vaughan)

WASHINGTON (Dow Jones)—Insurance giant Mutual of Omaha will see less of a hit from a $10 billion-a-year industry-wide tax on health insurance providers, under the terms of a deal worked out between Senate Democratic leaders and Sen. Ben Nelson (D., Neb.).

Under revised Senate health legislation unveiled Saturday by Senate Majority Leader Harry Reid (D., Nev.), the tax on insurers will begin in 2011 at $2 billion a year, eventually rising to $10 billion annually. The tax is to be divided up based on each company's market share.

Senate aides who reviewed the legislation said provisions in the revised bill are specifically crafted to protect Nebraska insurers, including Mutual of Omaha.

The tax carve-out appears to be one of several concessions Nelson won from Democratic leaders before agreeing to add his vote, the final one needed to secure passage in the Senate, to the healthcare measure.

''The biggest issue for us was abortion,'' said Jake Thompson, a Nelson spokesman. ''But Sen. Nelson also wanted to ensure that Nebraskans won't face increased premiums as a result of a fee that was going to be imposed.''

Nelson inserted a provision that will carve out supplemental Medicare insurance from that tax. That provision will benefit Mutual of Omaha, but also other insurers that offer so-called Medigap policies, Thompson said.

Nelson also won support for a provision ensuring that Nebraska won't have to foot any costs for new Medicaid enrollees. That is important because the Senate bill expands Medicaid eligibility, potentially increasing costs for many states under a cost-sharing system with the federal government.

Most other states will be required to pick up between 5% and 18% of coverage costs for new Medicaid enrollees, with the federal government picking up the remainder.

The revised bill introduced by Reid also carves out non-profit insurers that meet certain criteria, especially in Nebraska and Michigan, from the new industry-wide tax.

''Several states had unique circumstances, and [Reid] thought it was appropriate to provide a narrow exemption from the fee for a couple of states that had unique circumstances,'' a Senate Democratic aide said in a conference call with reporters.

''Nebraska also had circumstances that necessitated the relief,'' the aide said, without elaborating.

''This legislation is good for our country and good for Nebraska,'' Nelson said in announcing his support for the healthcare bill Saturday.

One provision in the bill is narrowly tailored to apply to Blue Cross/Blue Shield of Nebraska, Nelson's spokesman said. It says that a company that is a mutual insurance company and had a market share in a state of between 40% and 60% in 2008 would be exempt from the tax.

Senate transparency rules enacted after Democrats took over the chamber in 2006 discourage narrowly crafted tax breaks, also called tax earmarks. Senators are required when offering amendments that include such provisions to publish a list in the Congressional Record, and the amendments could be subject to procedural objections.

The Senate GOP aide said that carving one insurance provider out of the tax could put it at a distinct advantage with respect to competitors. The Joint Tax Committee has estimated that the tax could result in increased premiums to consumers of between 1% and 1.5%.

''If one company is protected from that fee, you're talking about a significant pricing differential,'' the aide said.

Mr. GRASSLEY. Likewise, single State Medicaid provisions might be determined to be congressionally directed spending items. Under rule XLIV, the determinations are not made by the minority staff.

In order to ensure transparency of narrow provisions, the burden is on the sponsor to provide the list.

This is my parliamentary inquiry: Does rule XLIV of the Standing Rules of the Senate require that if a Senator proposes an amendment containing congressionally directed spending or a limited tax benefit, that the sponsor of those provisions and the names of the Senators requesting them be printed in the RECORD?

The PRESIDING OFFICER. Paragraph 4(a) of rule XLIV requires that a Senator proposing an amendment containing a congressionally directed spending item ensure as soon as practicable that a list of such items be printed in the CONGRESSIONAL RECORD.

Mr. GRASSLEY. Has the majority leader provided a list of these special

deals and of the Members requesting them for the RECORD as required by the Senate rules?

The PRESIDING OFFICER. The Chair is not aware of whether that has occurred at this time.

Mr. GRASSLEY. So what is the situation as far as the rule being provided, as long as the Senate has not been made aware of this?

The PRESIDING OFFICER. This part of rule XLIV simply requires that the Senator mentioned make a good-faith effort to comply with paragraph 4(a). It does not impose a condition that would precede the amendment, that it could not be heard.

Mr. GRASSLEY. I yield the floor.

The PRESIDING OFFICER. The minority whip.

Mr. KYL. Mr. President, a lot of attention has been paid to the position of the senior Senator from Nebraska on this legislation. Page 98 of the amendment provides that the State of Nebraska is carved out from being responsible for paying for additional Medicaid patients added under the bill. It is the only State explicitly carved out from this requirement.

I address this as well to the chairman of the committee.

I ask unanimous consent that the pending amendment be set aside and it be in order to offer an amendment to extend to all States the same benefit that provides 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program. This would give the same treatment to other States that currently only Nebraska would enjoy under this bill. If the bill is a good thing for all States, then it seems to me it should be applied equally to all States.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, since that was the broader context of that intent and there are other States that are hurting as well, I ask unanimous consent that the pending amendment be set aside in order to offer an amendment to the extent that Colorado and Montana and Virginia would get the same benefit that provides 100 percent Federal funding to the State of Nebraska forever for their expanded Medicaid Program, which would give the same treatment to these other States that I have mentioned that currently only Nebraska would enjoy under the bill.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, reserving the right to object, as enticing as that might sound, I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, following up on that, I happened to see Governor Schwarzenegger on television today. He said he had initially been inclined to support this legislation until he realized what it would do to his Medicaid budget in California—it would cost them $3 billion and they do not have that $3 billion. Indeed, they didn't have the money necessary to meet their current obligations under Medicare.

Therefore, I ask unanimous consent that the pending amendment be set aside and it be in order to offer an amendment to extend to the State of California the same benefit that provides 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program. This would give the same treatment to California as Nebraska would obtain.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Alabama.

Mr. SESSIONS. Mr. President, I think I would be remiss if I did not ask unanimous consent that the amendment be set aside and that these provisions be extended to my State of Alabama which is also in a serious condition financially and whose Governor has expressed unequivocal opposition to the burdens on the State Medicaid Program that passing this legislation would impose. I ask unanimous consent that the same benefit that provides 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program apply to the State of Alabama.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Alabama.

Mr. SESSIONS. Mr. President, why are we here voting tonight at 1 a.m. and probably voting all the way to Christmas Eve? I think the answer fundamentally is on the health care matter, that after much talk about a bipartisan health reform effort and some work toward that end, the President and the Democratic leadership in the Congress decided they had the majorities in the House and the Senate and that they would use those majorities to pass the legislation that they wanted without Republican input. I know that has happened on occasion around this Senate, but I don't believe it has ever happened on a matter of such significance.

These major kinds of policy matters have historically been bipartisan or had substantial bipartisan support. We are talking about health care, involving every American. We are talking about raiding, not strengthening, Medicare, a program that is already in deep trouble. We are talking about a major governmental intervention into one-sixth of the American economy. These are pretty big issues.

Even more significantly, our Democratic colleagues are concerned about the American people, who, by consistent majorities, reject this plan. They are fearful of them. So they want to move this bill forward now, sooner, faster, quicker, with less discussion and less debate. Instead of working together to improve a broken health care system, the decision has been reached to railroad this bill through before Christmas.

They say the President promised reform. He was elected and so they will just ram it through no matter what the American people, for that matter, think.

Just for example, a recent CNN poll—I do not think that is a rightwing entity—61 percent oppose the Senate bill, only 36 percent support it. Just a little more than one-third support and over 60 percent oppose. Those are lower numbers than President Bush received for his plan to reform Social Security.

So, why do they do this? Well, because they think they know better than you do, because they want to make history. And if you object—as the Senator from Rhode Island said this morning—you and the rabble disagree with us, why, you are mean-spirited, coldhearted, and fearful—as to whatever those words were—you are just like those great unwashed whom you represent. So I think there is an unusual amount of disdain here for any political and substantive disagreement about this incredibly important legislation and I think a disdain for the concerns of the American people, as represented in rallies, in tea parties, and in polling data.

Is this all just illogical fear? Are these people totally irresponsible to worry about the future financial condition of their children?

A colleague of mine showed me this great cartoon that showed a man standing beside Santa Claus, and Santa said: What would you like? I think the man was President Obama. And he said: Health care. And there was also a little boy, sitting on Santa's lap, and he said: What do I get? And Santa said: You get the bill.

Well, the people know this is a significant issue for the future direction of our country, and I think they are saying that this what not what they intended during the last campaign. I remember this defining moment—do you not?—when Joe the plumber accosted President Obama, and they discussed redistributing the wealth around. And what an effort there was to suggest that President Obama did not really believe in that idea, but that he believed in freedom and individual responsibility and was not going to tax the average person, and those kinds of things. So the campaign survived that little dust-up.

But I think the American people are saying: Fool me once—during the campaign—shame on you. Fool me twice, shame on me. They are not happy with this bill. Polls show the tea parties are more popular than the Republican or Democratic Parties. So I think this use

of raw power—the idea that we must get this bill done before Christmas, and we will pay any price necessary to get the votes to do it—is not good.

I am amazed that people would criticize those of us who do not agree with this legislation—and I am prepared to talk at some length about the substantive reasons about it—that we are somehow obstructionist because we would like to have more than 1 day, really, to consider a 383-page amendment and see what all was placed in it.

So my colleagues have been saying the people are misinformed and they have been subjected to lies and misinformation. Well, just a few days ago, I heard the President declare that if you do not pass this legislation, your insurance premiums are going to go up, which is not untrue. But what he did not convey—and I think most people understand already, however—is that even if the bill passes, premiums will go up some, double digits more than they would have gone up if the bill had not passed. A few people will see a modest—less than 1 percent, maybe some over 1 percent—reduction in the rate of increase in their insurance premium, but a lot of people are going to see double-digit increases in their premium, particularly the people who are not in group plans. Those are the ones for whom insurance premiums are the most unfair and who are getting rooked the most by insurance. We ought to be taking care of this problem because they are not in group plans and they are not in companies that subsidize it. They do not work for the government that subsidizes their health care.

But the President has the bully pulpit. He lectured the whole Congress. He hauled us out and talked about it in a joint address to Congress. He got $150 million from the big PhRMA drug companies to advertise in support of this bill, as it has been reported. Robert Reich, a great liberal, Secretary of Labor under President Clinton, scathingly condemned that deal that PhRMA made with the White House over the doughnut hole and their contribution for advertising.

I will just have to say, the majority has found no price too high, no depth too low in order to get that 60th vote so they can go forward. And we have got to get it done now, pass this managers' amendment that the majority leader has plopped down—the one that was written in secret and we just saw yesterday morning at about 10 o'clock.

Well, I will just say, how should we judge the overall merits of the bill? How should we decide whether to vote for it or against it? I would say that one good way is to judge it by its own promises, to judge it by what the American people have been told the bill will do, how much it will cost, and those kinds of things.

Well, there are some facts and some fictions here. We just need to be frank about it.

Fiction No. 1: We have been told that the total cost of the legislation is $871 billion. That is a lot of money, $871 billion. But what are the facts? When the new programs created by this bill are fully implemented, the bill will actually cost, over the first 10 years of full implementation, $2.5 trillion—three times as much.

Now, who is giving the best numbers here? Since we know most of the benefits do not start until 5 years from now, they score the first 10 years of the budget, the cost of the bill, and say it costs $871 billion. But if you take it from the first 10 years of the bill, as we would normally score a piece of legislation, it is $2.5 trillion—$2,500 billion. That is a stunning difference. It just shows what a massive piece of legislation this bill is.

According to the bill, Medicaid will be expanded up to 133 percent of the poverty level, but that will not happen until 2014. The insurance subsidies funded by the bill do not begin until 2014. So this is how they manipulated the numbers. So they say $871 billion. Not so. In fact, the managers' amendment increases Federal spending on health care to $200 billion rather than $160 billion projected under the original bill that came forward.

So we currently spend one-sixth of our GDP on health care. How much more can we afford to pay? And wasn't the original intent to rein in health care spending, to reduce the percentage of GDP going to health care?

Mr. President, how much time is left on this side?

The PRESIDING OFFICER. The Senator from Alabama has 6 minutes remaining.

Mr. SESSIONS. The business community as well as many others are expressing concern about the fact that this bill would not actually rein in health care spending. I thought the goal and I think most Americans thought the goal of the legislation was to figure ways to contain the growing cost of health care in America without reducing our quality and the magnificent care so many Americans receive. But it does not do that. In fact, the numbers show, independent accounts show that the percentage of our national wealth, our GDP, that will go to health care once this bill is passed—if it is—will be greater than if it is not passed. We should wrestle with those issues and do better.

What about another fiction? The President had promised—you have heard him—along with other leaders on this floor: This bill will not add one dime to the Nation's surging debt. But by any fair analysis, the bill increases both spending and debt.

First, I just have to say, when you pass 70 new government programs, expand Medicaid, and create millions of dollars in new subsidies, how can that not increase spending? But the bill is structured in a way so that its spending is covered by its new $519 billion in taxes. Well, if you raise taxes enough, you can make anything come out to a balance. They call some of these taxes fees, but they are still taxes and increased cost in the system. They include a $6 billion annual tax on the insurance industry as a whole. For the people we want to reduce premiums, we raise taxes on them $6 billion. It includes a $2.3 billion annual tax on the pharmaceutical industry. We would like to see less cost for drugs, not more. It includes taxes on medical device companies, $28 billion on employers that do not provide enough coverage according to the new standards and a 40-percent tax on plans that provide too much coverage, and $43 billion in total taxes raised through penalties on employers and individual mandates. All in all, you are taxed if you sell insurance, taxed if you buy it at the wrong level, and taxed if you do not buy it at all. Yet, contrary to promises, the bill does not lower individual family premiums, and for many, their out-of-pocket costs will increase. So this is not the kind of reform we were promised.

But one more thing. Always a part of health care reform was the acknowledged necessity to do something about the reductions in payments, reimbursements to doctors. This bill proposes cutting physicians' pay 21 percent. That is what it does—they ignore a $250 billion cost, and act as though they can use that money for the bill's new programs. But doctors were promised from the beginning that their payment reimbursements would be fixed. They cannot sustain a 21-percent reduction in pay. Doctors will quit doing Medicare work all over the country if that occurs.

Mr. ENSIGN. Will the Senator yield?

Mr. SESSIONS. I will be glad to yield.

Mr. ENSIGN. So let me ask the Senator, from what I understand about the so-called doctors fix, there is around a $250 billion cost to that. In this bill, there is no fix to that, from what I understand. Is that correct?

Mr. SESSIONS. That is correct.

Mr. ENSIGN. So the bill is either dishonest as far as the deficit is concerned because if you put the doctors fix in there, this thing actually hurts the deficit, or we are actually seriously hurting doctors because this bill will require a lot more doctors in the country to take care of those new people who will now have health insurance in the country. Is that correct?

Mr. SESSIONS. Exactly correct. What we are doing, I think you can say fairly—boil it down to this—we are raising taxes over $500 billion, we are cutting Medicare nearly $500 billion—so, around $1 trillion total. And we are using none of that money to fix the doctor payment deficit we know has to be fixed. Instead that money is going to new programs. We cannot cut the doctors 21 percent. Congress has filled that money in every year for nearly 10 years now, and we have to fill it in in the future. Any good health care reform would do what it promised to do from the beginning, which was to eliminate this cut.

One proposal has been to do it simply by adding, throwing it to the debt.

Mr. ENSIGN. Will the Senator yield further?

Mr. SESSIONS. I will be pleased to.

Mr. ENSIGN. So would the Senator describe this almost as a shell game?

Mr. SESSIONS. Absolutely.

Mr. ENSIGN. The doctors fix would be the pea. Where are they hiding the pea? Because we know this is going to be fixed. It is always fixed. Every year, we fix the doctors' pay. And yet, to hide the true costs of the bill, then, the doctors' fix is really the pea in that little shell game and they are just hiding it. Is that correct?

Mr. SESSIONS. Exactly. The President looked the American people in the eye and he said: This legislation will not add one dime to the national debt.

The PRESIDING OFFICER. This block of the minority's time has expired.

Mr. SESSIONS. Mr. President, if I could ask for 30 seconds to finish.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. How much time did he ask for, Mr. President?

The PRESIDING OFFICER. The Senator asked for 30 seconds.

Mr. HARKIN. No objection.

Mr. SESSIONS. So the President promised to end the doctors coming to Washington every year to try to make sure they don't get cut 21 percent, but he has not done it. This bill's promises simply do not add up. This bill, when you assume the doctor fix, clearly adds to the debt. It must be added as part of the reform. There are a number of reasons to oppose the legislation, and I urge my colleagues to do so.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. I understand now the Democratic side has 1 hour, from 6:30 to 7:30?

The PRESIDING OFFICER. The Senator from Iowa is correct.

Mr. HARKIN. Mr. President, I yield myself the time from 6:30 to 7.

Mr. President, I was in my office a little bit ago, and I was watching the comments made by the distinguished minority whip, the Senator from Arizona, Mr. KYL. He went on at some length about how this vote at 1 a.m. we are going to be taking is tough on some Members. He mentioned specifically our distinguished colleague, Senator ROBERT BYRD, who is not up and about at those hours, and they would have to drag him out of bed and bring him down here for this vote. Senator KYL felt very sorry for Senator BYRD that we would do that at 1 a.m.

He said the majority leader has the power to put this vote back. We could do it at 9 a.m. in the morning. Well, he is absolutely right; we could do it at 9 a.m. in the morning. But because of the intransigence of the Republican side, because they are not willing to let us have these votes without expending the 30 hours under the rules—under the rules—the cloture motions have been filed and, of course, the Republicans, which is their right, can burn up 30 hours.

Well, after the first vote at 1 a.m., the clock starts ticking on the next 30 hours for the underlying substitute. And then after that 30 hours, there is the underlying bill itself, and that gets 30 hours. So if the Republicans really want, they can burn up 90 hours. I ask, to what end? To what end? We have the 60 votes. No one doubts that. There are 60 votes now to pass this bill. So to drag this out and to cause people to come in at 1 a.m. in the morning is not on the Democratic side, it is on the Republican side.

So when I heard the distinguished Senator from Arizona pleading to put the vote off, I thought to myself: Well, if that is what the Republicans would like to do, there is a simple way to do that. You simply move the vote we are going to have at 1 a.m. to 9 a.m. tomorrow morning, and then you have the intervening hours from 1 a.m. to 9 a.m. count toward the 30 hours for the next vote. It is simple, very simple.

So I took that to heart, and I asked our staff to type up a unanimous consent request, and we have given a copy to the other side. So that is what my unanimous consent will do. It will ask that the vote occur at 9 a.m. tomorrow morning, but that the intervening hours from 1 to 9 would count toward the 30 hours for the underlying substitute.

So, Mr. President, I ask unanimous consent that the cloture vote scheduled to occur at 1 a.m. Monday, December 21, occur at 9 a.m. Monday, December 21; and that if cloture is invoked, the postcloture time be considered to have begun at 1 a.m.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. Mr. President, reserving the right to object, we are not the party that spent 8 weeks putting this together to delay everything. We are not the party that spent all the time putting this amendment together that we are trying to do without any input from the Republicans. We are trying to have time to both review this and let America know what is happening. We know the Democrats have kept people from going home now for 3 weeks so they wouldn't have to listen to the voters at home who are really upset with this bill.

So we would agree to the request to set the vote at 9 a.m. if the Senator will modify and strike the retroactive cloture time. We want the time.

Mr. HARKIN. My initial request stands, Mr. President.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. HARKIN. So, Mr. President, here we go again. There they go again. You know, they want to delay, delay, delay, delay; obfuscate, obfuscate, obfuscate, and try to kill this bill by delaying it ad infinitum. They would be happy to delay this through Christmas, through the New Year, and January and February. Why? They would be happy to delay this bill for 10 years or more because they don't want it to happen. That is really what is going on.

I say to my good friend from Wyoming—and he is my good friend; he is a great Senator—I thought—we did—in our committee, we got the bill through open and aboveboard. I think the reason we are here at this time is because we Democrats bent over backwards to accommodate the minority. We did in our committee, and I can say that Senator BAUCUS went the extra mile—no, he went the extra 10 miles. He went the extra 100 miles on the Finance Committee to involve and to get the minority side involved. In the end, only one Republican would vote for it, and we know who that was, the Senator from Maine.

We could have emulated the Republicans. We could have emulated what they did when they were in the majority in 2001. I was here. I remember it well. When they came up with this crazy tax package that cut taxes for the wealthiest in our country, stole the surplus we had built up under President Clinton by the year 2000 where we were looking at surpluses on into the future, and they came up with all of these big tax cuts for the wealthy, guess what they did. They didn't involve us at all. They did reconciliation where they only needed 51 votes. Under reconciliation, under the rules of the Senate, as the Presiding Officer knows, there is no filibuster. You cannot filibuster a reconciliation bill under the rules.

So if they had done their tax bill in 2001 like we are doing this, we could have delayed. We could have had some input into that, but they said no. They just went right to reconciliation. We could have done that with this bill. We could have done that with this bill.

I remember having discussions with members of our caucus and others saying: No, no. And the President, President Obama, wanted to do this as bipartisanly as possible to involve the minority in a constructive process. So that is what we decided to do, to do it in a very constructive, open process. What it has gotten us is total—total—obfuscation and delay and trying to kill the bill by the minority. But we will persevere. We started this open process, and we are going to finish this open process. The die is cast.

We have a vote at 1 a.m. I wish it could be 9 a.m., but you just heard the Republicans object to that because I just asked that the intervening hours be counted toward the next 30 hours, and they wouldn't even do that. So the reason we are here is not because of the Democrats. We are here because the Republicans simply don't want this bill to pass.

That is really the reason.

So we are going to vote. We are going to vote at 1 a.m. On the face of it, it is

really a technical, procedural vote, but it is something more than that. With that vote at 1 a.m. on the managers' package, on cloture on the managers' package, we will have reached a pivotal point at 1 a.m., a pivotal point in a decade-long quest to pass comprehensive health care reform. We have reached a crossroads, a kind of a point in time just as the Senate did in 1935 when we passed Social Security, or in 1965 when we passed the Medicare bill. Each of those bills was a giant step forward for the American people, but each was bitterly opposed in this body by defenders of the status quo, the Republicans.

In each case, Senate opponents waged a strident campaign of fear, warning that the passage of the legislation would lead to socialism. Senator Robert Taft from Ohio kept calling it socialism. We are going to ''Sovietize'' America. You can read it in our history books. But in the end, a critical mass of Senators rose to the historic occasion. Senators ignored the dark warnings and the demagoguery. They voted their hopes and not their fears. As we know now, in retrospect they passed laws that transformed America in profoundly positive ways.

The Senate has arrived at another one of those rare historic moments. This time, we are attempting to pass comprehensive health care reform, a goal that has alluded Congresses and Presidents going back to the administration of Roosevelt. People think I am talking about Franklin Roosevelt. No. I am talking about the administration of Theodore Roosevelt.

Once again, advocates of reform faced bitter opposition, including the filibuster we are seeing now and that has been going on for weeks by defenders of intense interests in the status quo. Once again, each Member of this body must make a choice: fear or hope; stick with the broken status quo or embrace bold change with all of its uncertainties.

The other side is saying what about this? What is going to happen here? I keep talking about this bill we are passing. It is not like the Ten Commandments carved in stone. It is a bill. It is a law. Laws change as times and conditions change, as we get different information. So there are uncertainties in the future. The future is uncertain. But we can lay down a good start toward bringing people into a health insurance system and stopping some of the most horrible practices of the health insurance industry, moving us toward more of a health care system rather than a sick care system.

So, yes, there are uncertainties, but we know one thing: The certainty of the status quo leads to too many people not having any kind of health care whatsoever. It leads to people dying younger than they should because they don't go in for their checkups and their screenings, children and others.

We know the other side made clear sometime ago they wanted to obstruct and delay and filibuster and kill this bill. As far as my friends on the other side of the aisle are concerned, this floor debate is not about offering amendments to improve the bill. It is really not about allowing more time to fully read it and understand the bill. That is nonsense. It is not about playing a constructive role to pass a better bill. All the other side wants to do is kill this bill. Period.

All this yakking that is going on—I was home this afternoon and I turned on C–SPAN and I was listening to the debate. And I thought, you know, people are at home. They are getting ready for Christmas. The trees are up. People are feeling good. Here we are going back and forth, back and forth, back and forth, but people have tuned this out.

They really have. It is Christmastime and people have tuned this out. Yet we are here.

We are here for a good reason. We are here because we are determined to pass meaningful health care reform for America, and we need to do it before Christmas.

Well, again, in the defense of the broken system and the status quo, the Republicans joined at the hip with the health insurance companies. They use the same talking points, the same distortions, the same bogus, cooked-up studies, the same outrageous stories about death panels and pulling the plug on grandma. We have heard all that from the other side, week after week, month after month. Every step, as I said, we on this side have acted in good faith. We did not go the reconciliation route. In our futile quest for bipartisanship, we have repeatedly given the Republicans more time.

In the Senate HELP Committee, under the great leadership of Senator DODD, we spent nearly 3 weeks marking up the bill. No amendments were denied. Republicans could offer any amendment they wanted. It took 13 days, a total of 54 hours of meetings. We went out of our way to accommodate our Republican colleagues. We accepted 161 of their amendments, either by vote or just by accepting them. After all that time, all that goodwill on our side, accepting 161 of their amendments, every Republican on the committee voted against the bill.

Now, every time I have told this story in Iowa or wherever I have been, people shake their heads. They say: What? They offered 161 amendments? Surely, they would have been kind of happy with that. They might have voted for the bill. They don't understand that. Every single Republican voted against it after all of those amendments.

In the Finance Committee, deliberation on the bill stretched out for months solely to accommodate the wishes of the Republican members of the committee. Yet after all that time, despite the fact that Senator BAUCUS had bent over backwards to pursue bipartisanship and to accommodate the minority's requests—he acted in good faith at every step of the way—all but one Republican on the committee voted against the bill.

Now, today, Republican Senators say they are opposing the cloture motion because they need more time. They say we are rushing things, rushing things, there is a big rush going on. Good grief. This bill has been on the Senate floor for 21 days. We have been deliberating about health care reform for almost the entire year. Congresses and Presidents, as I have said, have been trying to get this done since Theodore Roosevelt.

So Republican colleagues say: Slow down. You are moving too fast. Well, that is absurd and disingenuous. We have to ask ourselves: Are our Republican friends going to be more constructive, more willing to act in good faith after the Christmas or New Year's break? Of course not. Their aim, understand, is not to improve the bill or to even understand it; it is to kill health care reform. Period. That is all it is. They just want to kill it.

Now, because they don't have enough votes to kill it outright, they have opted for a course of delay and obstruction and filibustering. But let's be clear. They are not only delaying and obstructing the Senate; they are delaying and obstructing the millions of Americans who desperately need the reforms in this bill. They are delaying and obstructing the 31 million Americans who will finally get health coverage. They are delaying and obstructing the underinsured, millions of Americans who know they are just one serious illness away from bankruptcy and financial catastrophe. They are delaying and obstructing millions of Americans with preexisting conditions who can't get insurance. They are delaying and obstructing women in this country who face systematic discrimination by health insurance companies. They are delaying and obstructing Americans who fear if they get cancer or heart disease, their health insurance company will cancel their coverage.

Let's be clear. Again, Republicans are not only trying to kill health care reform, in doing so they are killing the hope for millions of Americans who are desperate for reform of the current broken system. Too many Americans are literally dying because they do not have health coverage and proper access to a doctor.

All told, nearly 45,000 Americans die each year because they lack meaningful health insurance. A Johns Hopkins study found that children without health insurance who are hospitalized are 60 percent more likely to die than those with insurance. Why? It is obvious. Kids without health insurance are much less likely to get preventive care or to be taken to a doctor in the early stages of their illness—60 percent more. Think about that. Children without health insurance who are hospitalized are 60 percent more likely to die than children who have health insurance. So that is the real cost of delay and obstruction on the floor of the Senate.

This is our job. We are here. We are going to finish this job. But it is a tragic human cost. And these victims can be found in every one of our cities, our farms, our rural communities.

I refuse to allow any obstacle to stand in the way of the Senate addressing the needs of these Americans. I have, along with my friends on this side, opposed the Republicans' filibuster. Likewise, I have been willing to disappoint many whose views I respect by agreeing to painful compromises in order to keep this bill on track. I agreed to those compromises not because I lacked passion or fight—I think my colleagues who know me know well enough that I can fight—I did so because of the harsh but unavoidable reality that because of the Republicans' obstructionism, we need 60 votes to pass this bill, and the only path to securing 60 votes was by making necessary compromises. But I add, that is also the way our predecessors in this body were able to get the votes to pass Social Security and Medicare, both of which had big gaps in coverage when they were first enacted. What they did is they passed bills that were sort of a half a loaf. Then they came back for the remainder of the loaf in the following years.

Despite these compromises, make no mistake, this remains a profoundly progressive bill. One analyst put it this way:

> This legislation will be the most important social policy achievement since the Great Society.

That is exactly why the rightwing in this country is pulling out the stops to kill it. This bill will usher in three huge reforms. First, this bill will be the biggest expansion of health coverage since the creation of Medicare. Some 31 million Americans who do not have coverage now will get it, thanks to this bill. This is a monumental achievement. We do this by expanding Medicaid and by providing subsidies to low-income, modest-income families.

In addition, if you are a small business owner, this bill will offer tax credits of 35 percent of employer contributions toward premiums in order to make it more affordable for small businesses and their employees to have health insurance. That 35 percent will go up to 50 percent. But the 35 percent starts next year. That is why I have said many times in my State of Iowa, and around it, that actually the biggest winners under this bill, aside from the totally uninsured, are small businesses and the self-employed. Small businesses and the self-employed are the big winners in this bill.

What is more, our bill will end the discriminatory practice of jacking up premiums for businesses because an employee is older or has a preexisting condition. They will not be able to do that anymore.

Through these new health insurance exchanges, small businesses and people currently without access to affordable coverage will be able to shop and choose from a menu of quality health plans, much in the same way Members of Congress do.

This bill does much more than extend health coverage. The second great reform in this bill is an array of provisions cracking down on pervasive, outrageous abuses by the health insurance companies, abuses that currently leave most Americans just one serious illness away from financial catastrophe.

Right now, the health insurance industry in this country is extraordinarily profitable. But these profits come at a staggering human cost. Think about it. When Americans get a diagnosis, let's say, of cancer or some other grave illness, they fear two things: First, they fear the illness and, second, they fear the health insurance company. They wonder, is my company going to authorize treatment and pay the bills or will I have to go to war to prevent it from sticking me or rescinding my policy?

I always tell people: Look at your policy. Is there a rescission clause in there? I have had so many people say: What is a rescission clause? It is a little clause in there, probably in the fine print, and it says that when your policy is up for renewal, the insurance company can terminate you. They do not have to renew your policy. This is what happens. Someone gets a very serious long-term illness such as cancer or heart disease. When their policy is up for renewal, the insurance company says, no, they will not renew your policy. Now you are out in the cold with a preexisting condition. Now you can't get insurance anywhere. This bill will end that practice.

Health insurance companies now employ whole armies of claim adjusters just to deny requests. In fact, the health insurance companies give bonuses—they reward people for denying claims, saying no to policyholders. In the State of California, the largest insurers deny one out of every five requests for medical claims, even when recommended by the patient's doctor. One large insurer, PacifiCare, denies medical claims nearly 40 percent of the time. Think about that. That is almost one out of two. CIGNA denies claims 33 percent of the time. So if you get a terrible illness and you are insured by PacifiCare, good luck in getting them to pay for your medical treatment.

Republican Senators give us all the scare talk about a government bureaucrat standing between you and your doctor. Right now, we have corporate bureaucrats standing between you and your doctor, and they earn good evaluations and bonuses and money for denying you coverage.

I can remember a town meeting I had in Mason City in August, one of those famous town meetings. Toward the end of it—it was OK. There was a lot of contention there, people voicing their concerns, as they ought to do, as they have a right to do. But at the end, there was a man sitting down in the front. I thought, this will be my last one. I called on him. He stood up and he said: You know, I have been a doctor here for over 40 years in Mason City—40 years.

He said: I can say honestly during those 40 years, I have never once had a government bureaucrat come between me and my patients on Medicare or Medicaid. He said: However, I can't tell you how many times during those 40 years I have had insurance bureaucrats come between me and my patients.

This is a doctor, practicing for 40 years, and never once did he have a government bureaucrat come between him and his patients.

Nearly 62 percent of bankruptcies in the United States are linked to medical bills. And here is the kicker: Nearly 80 percent of those are people who had health insurance.

When is the last time you ever heard of a health insurance executive claiming bankruptcy? I would like to find one someplace.

The American people have lived in fear and under the heavy hand of these health insurance companies long enough. But help is on the way.

Let me mention a few of the ways this bill immediately cracks down on abuses by the health insurance industry. First, if you are uninsured with a preexisting condition, the bill would give you access to affordable coverage without discrimination. Our bill immediately bans those rescissions I talked about where the insurance company can rescind your policy. We stop that right away.

We prohibit insurers from imposing lifetime limits on benefits, and we impose and restrict the use of annual limits.

Our bill ends discrimination against women. As I said, currently they pay as much as 48 percent more for the same coverage a man has.

Our bill requires insurers right away, next year, to let children stay on their family's policy until they are age 26. Those are a few of the things.

But there is a third area in this bill I have championed for many years, and in many ways I think it may be the most profound part of the bill, and that is a whole array of provisions promoting wellness and prevention, turning America into a general wellness society.

To this end, at the clinical level, the bill requires reimbursement for proven, cost-effective preventive services such as cancer screenings, nutrition counseling, and smoking cessation programs. This means health professionals will be able to offer these services to you before you get diabetes or cancer or emphysema.

For essential screenings and annual physicals, there are no copays, no deductibles. We encourage people to do this so they will not have to pay a copay or deductible.

Our bill makes major new investments in community wellness and public health, and we help businesses both large and small create workplace wellness programs for their employees.

One thing I do not think has been mentioned before, our bill requires large chain restaurants to post basic nutritional information right on the menu so consumers, when they are going out to eat, can make healthy choices.

What we are trying to do is change the paradigm from our current sick care system to a true health care system—one that keeps people out of the hospital in the first place. Our aim is to recreate America as a wellness society focused on healthful lifestyles, good nutrition, physical activity, and preventing the chronic diseases that take such a toll.

As a proud progressive, I make no bones about my enthusiasm for the three great reforms in this bill—vastly expanding coverage, cracking down on the abuses by the health insurance companies, and making robust investments in wellness and disease prevention.

Today we are closer than we have ever been to making Senator Ted Kennedy's dream of universal health insurance a reality. This bill has many authors. We have all been involved in it. But in a very real sense, this is Senator Kennedy's bill.

I urge Senators, when the vote occurs at 1 a.m., to vote their hopes, not their fears. Seize the moment. Let's move ahead. Let's vote for cloture. At long last, let's give every American access to the quality, affordable health care they need and they deserve.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, before my friend from Iowa, the distinguished Chair of the HELP Committee, leaves the floor, I thank him for his wonderful leadership and friendship in so many capacities and passion for what we are doing now. We are all here together knowing that in the process of legislating, you don't always get every idea you want. But you come together and you work for something that is good for the American people, and that is what we have done. I thank him very much for all of his leadership.

I wish to take a few moments to talk about how we actually got to this point on a Sunday evening—we are voting at 1 o'clock in the morning—and, frankly, what has been happening all year. I want to take a few minutes to talk about what has happened this entire year, the first year of President Obama's presidency, our first year in the majority, and then to speak a little bit as well about the very important legislation that is in front of us.

I do think it is important that we take a moment to recognize and address a very unfortunate milestone, look back on the year on what we have accomplished in spite of that milestone.

In April, the media celebrated President Obama's first 100 days in office. But here in the Senate, we can measure our progress by something else—not 100 days, but 100 objections from the minority party. Actually, 101 as of yesterday; objections, filibusters, delays, stalling tactics designed to stop us from helping the American people who are hurting in these tough economic times. That is more true in my State than any other place in this country. Our people, the great people of Michigan, have been hurting longer, have been hurting much more deeply than other places in the country because of the major economic transition, as well as the recession in which we are involved.

There is good news because while the Republicans were stalling and wasting time, we were working hard doing what the people of America sent us to do. I want to talk about what we have done in spite of the stalling. But I also want to take a brief moment to explain something hard to explain about Senate rules because people look at us and say: They objected, but why does that matter? Why does that matter?

Mr. President, as you know, when there is an objection, in order to overcome it—and it is called a filibuster—it involves invoking motions called cloture and it takes time. It plain takes time. So 101 times we have not been able to move forward because of an objection or we have had to go through this long process we are involved in right now.

I think it is important to briefly explain it because when Republicans object, as they are now, as they have been on so many occasions, our leader has to file what is called a cloture motion, and then you wait 2 days. You cannot do other business for those 2 days. We have done that over and over, wasting time while people in my State want us to be focused on jobs, on lowering their health care costs, on making sure we are doing the things that matter to them every day. But we stop and we wait 2 days. Then we vote on stopping the filibuster. Then we wait 30 hours, which is what we are doing right now. Then we vote on whether to proceed to the item. There are filibusters again. Then we file a cloture motion on the amendments or the bill. We wait 2 more days. Then we vote on closing a filibuster, and then we wait 30 hours, and then we vote on the amendment, which we will do tonight, and then we have to wait another 30 hours. In this case, another 30 hours.

It does matter when we say there have been 101 objections that have either stopped us or forced this process. It does matter. It matters because it has slowed down the ability to move to get things done.

The good news is that we have gotten things done anyway. We have gotten things done anyway because we are focused and committed to getting things done. We know the American people have waited too long. The last 8 years were about taking us in the wrong direction, with things that did not help most people, that put us in a huge deficit hole, that did not address health care or health care costs or jobs, or policies that made it worse.

We know that even though there have been 101 objections so far this year—and there will be more; there will be more—we are going to get things done for the American people.

It is amazing the stalling actually happened on the very first day of the 111th Congress on January 6 when Republicans objected to moving forward with an important public lands bill, something we had been trying to do for some time to protect and preserve our national parks, forests, and wilderness areas. But we passed that important bill anyway over their objections and three different filibusters, as the chart showed. Three different times we had to wait, wait 2 days, wait 30 hours, wait 2 days, wait 30 hours. But we passed it.

Since then, nearly every single week we have been in session, every single week but 4 out of 41 weeks, we have had to go through this process or have had objections. They have found something to object to or something to filibuster.

As I said, yesterday they objected for the 101st time, this time with a filibuster against providing affordable health insurance for over 30 million Americans. They have misused longstanding Senate rules and traditions to stall everything that might give this President and this Congress a victory.

I think it hurts all of us when the Senate breaks down as it has. Everybody is hurt by that—to stall everything that would help get Americans back to work or that would help 15.4 million Americans who are looking for work, and now to stop us, as I said, from extending health insurance coverage to over 30 million Americans. Their objections are about policy. They are about politics.

Earlier this year, objection 74, they stalled the unemployment bill, and their delaying tactics caused nearly 200,000 Americans to lose their unemployment benefits a couple of months before Christmas. They objected to the bill twice. They filibustered not once but three times before they voted unanimously. They voted unanimously for the bill. Why would you filibuster something three times and then vote for it unanimously? Not because you are concerned about the policy. The only explanation is that Republicans were trying to waste time—time that cost 200,000 Americans their unemployment benefits; the difference between paying the mortgage, keeping the heat on, putting food on the table, and possibly trying to keep health care going with a COBRA payment or in some other fashion.

Objection 4 was the Republican filibuster of the Lilly Ledbetter Fair Pay Act to make sure women get equal pay for equal work. Republicans filibustered and held up that bill, but we pushed forward. We passed it. We passed a very important equal pay for equal work bill in spite of it.

Objection 6 was to the American Recovery and Reinvestment Act which

has been absolutely critical to creating jobs, keeping our economy out of a depression. They filibustered that bill three times as well. But we overcame the objections, passed the Recovery Act, and made critical investments in transportation, in our schools, in our police officers, and in clean energy technology and manufacturing.

And, yes, we are seeing the difference in Michigan right now. Mr. President, $2 billion was part of the Recovery Act. I am pleased to say we have received a large part of that in Michigan to develop new battery technology manufacturing. We have at least six different firms that have announced and begun to develop manufacturing facilities for advanced battery development. Those manufacturing facilities are going to put thousands of people back to work. That was in the Recovery Act that was filibustered three times.

Objection 20 was to Senator Kennedy's Serve America Act, which we passed despite their filibuster, to help young people give back to their country through voluntarism and community service.

Objection 24 was to the Fraud Enforcement Recovery Act which cracked down on predatory lending and abuses by banks and mortgage companies. That bill was held up for nearly a month. But we passed it, giving real relief to millions of American homeowners.

We passed the credit card bill, Republican objection 32.

We passed the Helping Families Save Their Homes Act, Republican objection 33.

We gave the FDA the authority, finally, to regulate tobacco to help keep kids from smoking. That was Republican objection 38.

We passed the Travel Promotion Act which will help stimulate the suffering tourism industry across the country. That was objection 45.

We passed a true funding bill to make sure our soldiers in Iraq and Afghanistan had the support they needed despite having to file cloture to stop a filibuster—objection 47.

We passed the Defense authorization bill that included a pay raise for our troops and other help for our military and their families despite repeated filibusters and objections. And these were objections 54, 56, 57, and 58. Can you imagine? This was a Defense bill.

We passed the veterans health care bill, despite Republican stalling, to help caregivers of disabled veterans, women veterans, rural health improvements for veterans, mental health care for veterans, and support for homeless veterans. This was Republican objection 89.

Objection 98 was another filibuster against those pay raises for our troops just 9 days before Christmas.

Despite all of those objections, 101, we have been doing what we were sent here to do. We have focused on actions to help create jobs and strengthen our economy and focus on the things that families struggle with and care about every day to make people's lives better, not just a few, not just investment bankers on Wall Street, not just the wealthy folks who got the tax cuts in the last 8 years, but middle-class families every day who are trying to figure out: What about them? What about us? That is what we have been focused on.

We passed an extension of the Children's Health Insurance Program to provide health and dental care to nearly 10 million children. We passed legislation to reform government contracting and protect taxpayer dollars. We passed legislation to invest in health care, energy, and education. We passed the cash for clunkers bill, as you know, that I was proud to lead in the Senate that moved over 650,000 fuel-efficient cars off dealer lots and brought thousands of laid-off manufacturing workers back to work.

We passed legislation to support the growth of small businesses and to extend the first-time home buyers tax credit. And now, just a few days before Christmas, we are working to pass this critical, historic health insurance reform legislation. We are committed to getting it done.

Republican colleagues can object 100 times or 1,000 times, but we are not wavering in our commitment to do the right thing. Even though inaccuracies abound, even though misinformation has been said over and over about what this bill would do, we are committed to overcoming what has been the tidal wave of opposition from the special interests who control the status quo, who like it the way it is right now. We are determined to get beyond that and do the right thing for American families. Whether our Republican colleagues work with us or not—and we sincerely hope they do, and we have spent a tremendous amount of time this year reaching out to get bipartisan support—whether they stall or object, our job is to do everything we can to move America forward, and that will continue to be our focus.

As the distinguished Presiding Officer knows because we both sit on the Finance Committee, we have spent months reaching out with committees, with processes to get bipartisan support. But, as my dad used to say, it takes two to tango. It takes both sides to want to work together. Unfortunately, it appears the strategy that was put in place back at the beginning of the year, the very first day of session, with the very first filibuster, was just to stop us from being able to move America forward, to stop this great new President, to stop the majority in the Congress. But we have moved forward despite that.

I think often of what we could do if we hadn't had to deal with 101 filibusters, what we could have done in creating a clean energy bill, which would create more jobs in my great State, or dealing with other critical issues we need to deal with and we will deal with. As we slog through filibuster after filibuster in the coming year, we will do that. But now we have the opportunity in front of us to pass historic health insurance reform that, frankly, people have talked about for 100 years.

This legislation is not perfect, but nothing ever is when you start. It is a great framework, however, for putting in place the value, the principle that every American should be able to have affordable health insurance and that we are going to tackle the explosion of costs that have hit businesses large and small, that have hit taxpayers, and to bring those costs down over time. That is what we are involved in right now, and we are going to get it done.

We could have voted much earlier, rather than keeping our staff here until 1 a.m., and we will vote again after we run the next 30 hours, which will be, I believe, Tuesday morning. We could vote and be done with the final passage at that point. We know where the votes are. We have the votes to pass this. But it appears we will be here until Christmas Eve. Mr. President, I do not mind for myself. I, of course, want to be home with my family, as I know you do. But I think about my brother, who drives for UPS, and I know he will be working on Christmas Eve, as a lot of Americans will be working on Christmas Eve. And if we need to be here until Christmas Eve to do something that will positively affect every American, I am willing to do that. I am willing to do that if that is what we need to do.

Let me take a moment to talk about the bill in front of us. The bill in front of us literally saves lives, saves money, and saves Medicare, and I am very proud that in the managers' amendment, the amendment we will be voting on at 1 a.m. today, we have made it even better.

I am very pleased to have helped to lead a section related to small business tax cuts. Along with our chair of the Small Business Committee, Senator LANDRIEU, and another strong advocate, Senator LINCOLN, we have been working on provisions that will make sure there are small business tax cuts that start immediately—next year—after the bill passes, $40 billion in tax cuts in total to help small businesses afford health insurance for themselves and their workers.

In our amendment, we also provide even tougher insurance reforms.

In the underlying bill, we lay out a whole health care bill of rights. I remember coming here in the year 2000, and the Patients' Bill of Rights was the major thing we were trying to get done. We were in the minority, the Democratic minority, but we were working hard to do that. It was my first opportunity to work with Senator Kennedy. We believed strongly that we needed to take insurance company bureaucrats out of the middle—from between doctors and patients. That is in this bill. Those kinds of reforms are in this bill and only one of many things that are in this bill.

We have toughened it up so that if insurance companies, between now and when the new group insurance pool takes effect, are raising their rates too high, spending too much on profit and administration, then taxpayers, ratepayers, will get a refund. And we hope that will put pressure on them not to continue to raise rates or try to do what the credit card companies have done before the bill takes effect—raise their rates. So we have put new protections in and other protections as well to make sure that the majority—the vast majority—of every dollar a family puts into premiums actually goes for their medical care rather than for profits and administration.

In total, we have $430 billion in tax cuts to create affordability for families and for individuals, to help them afford health insurance. With that, overall, this is a tax reduction—this bill is—for the American people, and it is a reduction for taxpayers because it lowers the deficit in the first 10 years and on into the future.

I am going to take just a moment to give a sense of what is in the bill as it relates to new coverage and the benefits.

We know the majority of us have health insurance already. In Michigan, it is about 60 percent of the people, and in other places it is 50 or 55 percent. But we have what is called an employer-based health insurance system. So we have started from the basis that people should be able to keep what they have, and we have built on that. The majority of people have either employer-based insurance or they have Medicare or Medicaid or veterans services or other public services. So we started from the basis that we want to make current health insurance more secure, more stable. The insurance reforms we are putting in place for those plans that take effect—or new plans after this takes effect—will include the elimination of preexisting conditions, the elimination of what is called rescissions—the ability to drop someone if they have gotten sick—and the elimination of discrimination.

One of the things I was surprised to learn about, in terms of how extensive it is, as we went through this process is that women are paying, on average, 50 percent more than men for the same coverage in the individual insurance market or maybe even less coverage. Because a woman is in her childbearing years or perhaps has been pregnant and may be viewed as having a preexisting condition, some women might not be able to find health insurance.

So those who have insurance today, as they attempt to get new plans, will be able to take advantage of all of the insurance protections—our health care insurance bill of rights—in the bill. And this is very important.

Also, people with insurance today will actually, over time—and it will take some time for this to happen—but as others who do not have insurance now are able to afford health insurance and become able to get health care, there will be fewer people using emergency rooms. There will be fewer people needing other kinds of services that actually end up coming back, in terms of cost, to all of us who have insurance today because when someone walks into the emergency room sicker than they otherwise would be if they had seen a doctor, they get treated, as they should, but then the hospital has to make up the cost, so they put it on people who have insurance today. That is estimated to be about $1,100 in hidden costs for individuals. So we are going to see those kinds of costs come down and other changes and efficiencies and quality that will help people with insurance today. So coupled with the insurance reforms, we will see more stability and more quality for people who have insurance today.

The major area of new coverage is in what is called the insurance exchange. For the 15 to 20 percent of the people who can't find affordable insurance today—and most of them, as our Presiding Officer knows, are small businesses or people who are self-employed or people who have lost their jobs and then lose their insurance—we set up a new group pool, which is a way for people to use the same leverage a big business does or the Federal Government does, just as the insurance policy for Members of Congress uses a pool. Then everyone can choose the insurance coverage they want within that pool and get a better deal. That is what we are setting up in the insurance exchange, with helpful tax cuts for families and for businesses and individuals to help them afford health insurance.

We are also giving a choice to States. For lower income working people, a State may choose to provide a basic health insurance plan rather than people getting a tax cut to go into the exchange. They can set up their own basic health insurance plan and bring down costs as well through the State.

For young workers—and this is one of the things I wish had been around a couple of years ago—we will be allowing parents who have their children on their insurance policies—after the effective date of the act, they will be able to keep their children on their insurance policies until the age of 26. That will give young people a chance to get a start in that first job knowing they have insurance until they are 26. And there are a number of other provisions in the bill for young people as well.

We are making Medicaid a true safety net for low-income people up to 133 percent of poverty. We are truly going to be able to say: If you lose your job, you won't have to lose your insurance. What an important thing to be able to say in terms of taking away that fear of losing your job and having nowhere to turn.

Improving Medicare. We are going to stop what have been overpayments to for-profit insurance companies and put that money back into closing the gap in prescription drug coverage under Medicare. It has been called the doughnut hole. We are going to close that. We are going to provide preventive care for seniors without out-of-pocket costs and lengthen the Medicare trust fund so that it is stronger for a longer period of time.

I am very proud to have worked with Senator KERRY to develop a way to provide support and help for companies that pay for the health insurance of early retirees, to lower their costs so that, in fact, we will be able to help those who have retired, voluntarily or involuntarily, so they will have the insurance they need until they can qualify for Medicare.

Let me close by saying this legislation is very much about saving lives. Forty-five thousand people lose their lives every year because they can't find health insurance they can afford. That is 45,000 families who will have one less person at the dinner table over the holidays because of lack of health insurance. Surely we can do better than that in our great country.

We will be saving money for small businesses, for families, for taxpayers, and bringing down the deficit—beginning to turn those costs downward rather than keeping them going upward in such an uncontrollable way.

Saving Medicare. We will be making sure Medicare is stronger out into the future and that our seniors have more help paying for their prescription drugs and preventative services as well.

When you get through all of it, we know it is hard to change the status quo because those who benefit from the current system don't want it changed.

The PRESIDING OFFICER (Mr. WYDEN). The Senator's time has expired.

Ms. STABENOW. But we do.

I thank the Presiding Officer.

The PRESIDING OFFICER. The Democratic block of time has expired.

The Senator from Utah, Mr. HATCH, is recognized.

Mr. HATCH. Mr. President, after weeks of closed-door clandestine negotiations, Senator REID finally emerged with a 383 page manager's amendment yesterday to the 2,074 page, $2.5 trillion tax-and-spend Washington takeover of our health care system.

Despite all the promises of ushering a new era of accountability and transparency in Washington by the President and the Democratic Party, the Reid amendment represents everything that Americans hate about Washington right now Chicago-style backroom buyoffs at the expense of American taxpayers.

At yesterday's press conference, when Democrats were asked about the Nebraska earmark for Medicaid funding, the majority leader simply replied, ''A number of States are treated differently than other States. That's what legislation is all about. That's compromise.''

So in addition to the Medicare Advantage deal to grandfather only Florida's seniors and the $300 million give-

away known as the Louisiana Purchase, we now know what the Democrats' version of compromise really looks like. In the Reid amendment, released yesterday, Vermont gets a 2.2-percent increase for 6 years in its Medicaid Federal match rate while Massachusetts gets a 0.5 percent increase for 3 years for its entire program. But the deal for the State of Nebraska takes the cake. Now we all know that any one Congress can't bind future Congresses but somehow Nebraska will receive a special carve out that would have the Federal Government pay for every dollar of its Medicaid expansion. The total cost of these Medicaid special deals—$1.2 billion.

So the next logical question is pretty straightforward—who will pay for these special deals? Well, the answer is simple. Every other State in the Union, including Utah, which are collectively facing $200 billion in deficits and are cutting jobs and education services to survive; our States will now pay to support these special deals for Nebraska, Massachusetts and Vermont.

According to the Congressional Budget Office, the Medicaid expansion in the Reid bill creates a $26 billion unfunded mandate on our cash-strapped States. Coincidentally, only one State avoids this unfunded mandate—Nebraska.

Let me now focus my attention on over a $½ trillion worth of new taxes, fees, and penalties on individuals, families, and businesses imposed by the Reid bill. The new fees begin in 2010, while the major coverage provisions do not start until 2014. Almost $57 billion in new taxes are collected before any American sees the major benefits of this bill, which are largely delayed until 2014. It is no wonder why this budget gimmickry creates an illusion of this bill reducing our national deficit.

Based on data from the Joint Committee on Taxation—the nonpartisan congressional scorekeeper—this bill would break President Obama's campaign promise by increasing taxes on 42 million individuals and families making less than $250,000 a year. This is even after taking into account the government subsidies provided to low- and certain middle-income individuals and families.

The Reid bill not only increases payroll taxes by nearly $87 billion but also imposes $28 billion in new taxes on employers who do not provide government approved health plans. These new taxes will ultimately be paid by American workers in the form of reduced wages and lost jobs.

According to a recent study of similar proposals by the Heritage Foundation, these new job killing taxes will place approximately 5.2 million low income workers at risk of losing their jobs or having their hours reduced and an additional 10.2 million workers could see lower wages and reduced benefits.

So with nearly $½ trillion in Medicare cuts and more than $½ trillion in new taxes, does the Reid bill actually do anything to control our Nation's skyrocketing health care costs? The answer, according to the Congressional Budget Office, is no. In fact, it will actually increase our national health care spending. I quote: ''Under the legislation, Federal outlays for health care would increase during the 2010–2019 period, as would the Federal budgetary commitment to health care. The net increase would be about $200 billion over that 10-year period.'' So what is the bottom-line? More taxes, more spending and bigger government.

Let me a take a moment to talk about the so-called abortion compromise in this bill. The language to prevent taxpayer dollars from being used to fund elective abortions in the Reid amendment is completely unacceptable. The new abortion provisions are significantly weaker than the amendment I introduced with Senator BEN NELSON to ensure that the Hyde amendment, which prohibits Federal dollars from paying for elective abortions, also applies to any new Federal health programs created by Congress. The Hyde amendment has been public law since 1976.

The Nelson-Hatch-Casey amendment, which is almost identical to the Stupak amendment that was included in the House-passed health reform bill in early November by a vote of 240 to 194; it is important to note that 64 of those Congressmen voting for the amendment were Democrats. Let me repeat that—the Stupak amendment was supported by 64 House Democrats. And, despite that vote and the support of seven Senate Democrats, the majority decided not to include this language in the Reid bill or the Reid managers' amendment. I find that absolutely outrageous.

Moreover, the Reid conscience protections are much weaker than those included in the House passed health reform bill. The House bill included the Hyde-Weldon conscience protections that have been included in the HHS appropriations bills since 2004; the Reid health reform legislation does not. The Hyde-Weldon language ensures that strong conscience protections are in place for medical providers who oppose abortion. These strong protections, which are currently Federal law, should also apply to the new programs created through the Reid managers' package.

The so-called abortion compromise does not stop there. The Reid amendment also creates a state opt-out charade. As noted by Cardinal Daniel DiNardo, the Archbishop of Galveston-Houston and the Chairman of the U.S. Catholic Conference of Bishops' Committee on Pro-Life Activities, allowing ''individuals to 'opt-out' of abortion coverage actually underscores how radically the underlying Senate bill would change abortion policy. Excluding elective abortions from overall health plans is not a privilege that individuals should have to seek as the exception to the norm. In all other federal health programs, excluding abortion is the norm. And numerous opinion polls should that the great majority of Americans do not want abortion coverage.''

Additionally, this provision does nothing to prevent one State's tax dollars from being used to fund abortions in other States. In other words, tax dollars from Nebraska or Utah could be paying for abortions in California or New York.

The Reid amendment also creates a new public option that will be run by the Office of Personnel Management, OPM, which, for the first time, creates a federally funded and managed plan that will cover elective abortions. Should this legislation be signed into law, the Federal Government will be funding elective abortions for the first time in over 30 years, against the will of the vast majority of Americans. For these reasons, I believe that the Senate health reform legislation is far inferior to the House passed bill when it comes to protecting the sanctity of life. It should come as no surprise to anyone that pro-life organizations from the U.S. Conference of Catholic Bishops to the National Right to Life Committee and the Family Research Council have expressed their strong opposition to this so-called compromise.

Finally, let me take a moment to talk about the individual mandate tax which has almost doubled from $8 billion to $15 billion in the Reid amendment. I have long argued that forcing Americans to either buy a Washington-defined level of coverage or face a tax penalty collected through the Internal Revenue Service is unconstitutional. The Constitution empowers Congress to do many things for the American people. Just as important, however, is that the Constitution also sets limits on our power. We cannot take advantage of the power without recognizing the limits.

We hear a lot about how Senators on this side of the aisle are supposedly defending the big, evil insurance companies while those on the other side of the aisle are the defenders of American families. This insurance mandate exposes such partisan hypocrisy. Let me ask one simple question: who would benefit the most from this unprecedented mandate to purchase insurance or face a penalty enforced by our friends at the Internal Revenue Service?

The answer is simple. There are two clear winners under this draconian policy and neither is the American family. The first winner is the Federal Government, which could easily use this authority to increase the penalty, or impose similar ones, to create new streams of revenue to fund more out of control spending. Second, the insurance companies are the most direct winners under this insurance mandate because it would force millions of Americans who would not otherwise do so to become their customers. If you do

not believe me, then just look at the stock prices of the insurance companies that have recently shot to their 52-week highs.

Right now, States are responsible for determining policies that best meet the particular demographic needs and challenges of their own residents. Massachusetts, for example, has decided to implement a health insurance mandate while Utah has decided not to do so. This bill would eliminate this State flexibility so that the Federal Government may impose yet another one-size-fits-all mandate on all 50 States and on every American. I cannot think of anything more at odds with the system of federalism that America's founders established—a system designed to limit government and protect liberty.

As I have said all year long, ensuring access to affordable and quality care for Americans is not a Republican or Democrat issue—it is an American issue. Unfortunately, the majority's arrogance of power has forced us down a path where ideology has trumped policy and big government has trumped American families.

Town hall after town hall and poll after poll tell us that Americans want us to step back, start over and reform our healthcare system in a step-by-step, fiscally responsible manner. This is a moment for courage and leadership. All we need is one Democrat to listen to a growing chorus of concerns from Americans across this great nation and stand up against this bill. I am going to do everything possible to make sure that the voice of Utahns and Americans everywhere is heard loud and clear in this Senate Chamber.

A vote to move this bill forward will be one of the most important votes this body has ever taken—a vote that is bigger than our parties or our ideologies; a vote that will fundamentally change the American landscape for generations to come and restructure one-sixth of our economy; a vote that will determine if we will give our future generations the same opportunities and the same sense of pride that has been our privilege. Make no mistake, our actions on this vote will not be without consequences. History and our future generations will judge us on this vote.

Despite the harsh realities of skyrocketing deficits and an exploding national debt, the majority's insatiable appetite to spend has not changed. Last weekend was a perfect example. At a time when we are already debating a $2.5 trillion tax-and-spend Washington takeover of our health care system, the majority jammed through a $1.1 trillion appropriations bill with a 12-percent year-over-year increase in Federal spending. But this is only the tip of the iceberg. There is already talk of raising our Nation's debt limit by almost $2 trillion to accommodate Washington's out of control spending habits.

Enough is enough. It is time to stand up and do what is right and there is no better time to do it than to vote against moving forward on this health care bill. The time for courage is now.

The historic blizzard in Washington yesterday was a perfect symbol of anger and frustration brewing in the hearts of the American people against this bill. I urge the majority once again to listen to the voices of the American people. My Republican colleagues and I are united with the American people in our fight against this $2.5 trillion tax-and-spend bill. There is still time to step back and start over.

One last thing. When you have one-sixth of the American economy involved, it deserves a bipartisan vote. To be honest, almost every major reform we have ever passed—in fact, every one I can think of—had a huge bipartisan vote. In this particular case, I don't know of one Republican who is going to vote for this. If you can't get 75 to 80 votes on something this important, this much of a reform, then we should start over and do it the right way.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, I have been interested in the conversation that has gone on this afternoon and this evening. I have heard, once again, the statement made on the floor about the number of people who die every year because they don't have insurance and how that is an absolutely essential reason why we have to pass this bill and indeed pass it now; we have to pass it before Christmas; we have to pass it immediately because there are tens of thousands of people who are dying because they don't have insurance; we have to pass this bill so it will provide insurance for them in January of 2014; we have to pass this bill because people are dying right now, but we are not going to have any of the things that will take care of them available for 4 years. So we can't take an extra week—we can't take an extra 10 days—because people are dying. But we can take an extra 4 years before we give them anything. I have had a very hard time understanding that logic. The mathematics do not add up for me. Delaying everything for 4 years—why?

We know why. The reason they are delaying the implementation of this bill for 4 years has nothing whatever to do with people's health or the fact that some people are dying. The reason the implementation date of this bill is delayed 4 years is entirely due to the computers in the Congressional Budget Office which say, if you started this program immediately, it would bankrupt the United States. It would blow the budget right out of the water. How do we make it look as if this bill is budget neutral? The way we make it look as if the bill is budget neutral is tell the computers—which cannot think, they can only add—we will start the revenue in this bill, the taxes in this bill, the increased premiums in this bill right away. But we don't start spending on any of the things we are giving the people to save their lives for 4 years. So the computers will say: All right, you will accumulate revenue for 4 years and that will be a big pot of money. Then, in the remaining 6 years of the 10-year term, which is all the computers are allowed to look at, you will have enough money over a 10-year period to pay for 6 years' worth of benefits. I will grant that. Actually, it isn't 6 years' worth of benefits because the money coming in will not be enough. So in order to make it look even better, they will project. The computers—which don't think, just add—say: Yes, this is right. We will project taking roughly $½ trillion out of Medicare and putting it into the same pot of money that is coming in, in the 4-year period, when nothing is going out.

But wait a minute. If we have 4 years of money coming in and nothing going out and we take $½ trillion out of Medicare and put it in the same pot of money, the unthinking computers can add that very well. They can come up and say: You know, this is going to be revenue neutral. Anybody who thinks this is going to be revenue neutral does not understand reality, certainly does not understand history.

Let's look at the CBO record of projecting health care costs. I remember when the Congress passed Medicare. There were very firm costs associated with Medicare. It was going to cost so much. We look back on Medicare, it has cost 20 times what was projected. In the first year, it cost more than was projected. This is in constant dollars, not in inflation-adjusted dollars. In constant dollars, Medicare costs 20 times what we were told. I remember during the debate in 1994, Joe Califano, the father of Medicare, the member of the White House staff who wrote the bill, wrote an op-ed piece in the Washington Post. He said: Congress, pay attention to our experience with Medicare. He said: We put Medicare together, but we got the cost projections. We put the whole thing together. We knew within months after it had passed we were wrong. We knew within months the costs were going to go way out of sight. We went to the Congress and told them and at that point it was too late. This thing had taken root. It had its followers. It had people who were solidly behind it. It was too late to fix it. It has ended up costing us 20 times.

Let's look ahead and see what we are doing if we pass this bill. No. 1, we are doing nothing for people who need coverage for 4 years. But we are locking into the Federal budget situation a brandnew entitlement. That is a word we use in Washington. Many of my constituents don't understand what it means. Let me do my very best to try to help people understand. First, as the word implies, the people who are receiving the money under an entitlement are entitled to it, whether we have the money to give it to them or

not. They are entitled to it whether they need it or not. They are entitled to it whether it makes any sense for them to get it or not. It is an entitlement that they will receive this money.

When Medicare was passed, the only entitlement we had was Social Security. Now we have Social Security, Medicare, and Medicaid. Along with the other entitlements built into the Federal budget, how much of the Federal budget goes out in entitlements? If we look at the budget for 2010, here is the cautionary lesson. The budget in 2010 on which we voted—I didn't vote for it—listed the projections out of the Congressional Budget Office as to how much revenue the Federal Government was going to have in 2010. The answer was $2.2 trillion. That is a lot of money. Then it said, next line, entitlement spending or mandatory spending, $2.2 trillion, which meant that in 2010, with the economy on its back and the revenue coming down as a result, every single dime we received out of the economy in 2010 was already committed.

So people would say: Senator, why don't you balance the budget? I would say: How am I going to balance the budget? How am I going to balance the budget with every dime that is coming in already committed and going out as an entitlement and outside the appropriations process?

Vote against an earmark.

Pardon me. The entire government, all the Embassies overseas, the Defense Department, Transportation, Education, national parks, name it, whatever it is, every dime to keep the government going had to be borrowed, not because we didn't have any revenue. We had $2.2 trillion worth of revenue which, by itself, would have covered the cost of keeping the government open. But we couldn't touch a single dime of that $2.2 trillion because all of it was tied up with entitlements. So what are we doing in the face of that experience? We are creating a new entitlement to add to those we already have.

The realities of Federal budgeting are these, and they are not unlike the realities of running a business. I have run a business. I understand how the very best projections, the very best forecasts can go awry. You have a new product. You think it is going to do well and you forecast X millions of dollars in revenue from this new product. You look at what the product is going to cost you and you forecast that cost and you put the two together and you say: All right, we will have X in revenue and we will have Y in costs. As a result, we are going to have Z in profit. So you go out and you build the product. You commit for the raw materials. You pay the people in your factory to produce it, and you put it on the shelves. Now you are at the mercy of the customer, because if the customer decides he doesn't like the product, your projections of the amount of revenue will not save you from the enormous loss that will come.

Yes, you are right on the Y you are spending, but you were wrong on the X you thought you would get in. Instead of having the Z you planned to have as profit, you have a huge loss on your hands. Conversely, I have this happen, too. I have done my forecasting. I have laid down the plan for how much of the product we are going to produce. I have done my forecasting of how many will sell, and the product went crazy. It jumped off the shelves. All of a sudden, I was stuck with empty shelves and had to scramble to produce more and more and more in order to meet demand.

In the Federal Government, we don't have a product but we have expenses, just the same as doing a manufacturing operation. We don't have sales, but we have taxes. Our taxes are dependent upon the viability of the economy. The one fundamental lesson we all should learn is this: We can accurately predict the expenditures that are going out, just like in the business I could predict what it would cost me to produce the product, but we cannot accurately predict the revenue that will come in, just like I can't accurately be sure what the sales will be. We did a spending pattern based on revenue when the economy was strong. Suddenly, the economy turned weak and the revenue dropped off to $2.2 trillion. We were stuck.

Does this make any sense in the face of that reality? We can determine the spending, but we can't determine the revenue. Does it make any sense in the face of that reality to build in increased spending in the form of another entitlement in the hope that the revenue will be there? The only way the majority leader is able to make this bill look as if the revenue will be there is with a series of budget gimmicks the likes of which I have never seen, some of which I have already discussed.

The first budget gimmick is to say the revenue will be there because we will have 10 years of it and only 6 years of expenditure. The revenue will be there because we will be able to find $½ trillion worth of waste, fraud, and abuse in Medicare. I will stipulate there is probably $½ trillion worth of waste, fraud, and abuse in Medicare over the period of time we are discussing in this bill. We have been looking for it for more than 10 years and have been unable to find it. This bill, instead of trying to take a scalpel to Medicare and cut out the areas of waste, fraud, and abuse, uses a sledgehammer to smash Medicare and say we are going to knock $½ trillion out of it and hope that in the process of doing so, we will hit the waste, fraud, and abuse without hitting anything else.

We have 4 years on the timetable laid down by the majority in which to get this right. The majority has decided that if, indeed, people are dying because they don't have health care, they can continue to die because they don't have health care for 4 more years. I think in the face of the smoke and mirrors we are seeing with respect to this budget, we can afford, during that 4-year period, at the front end of that 4-year period, to take a few more weeks to do this right. That is why I am here and that is why my Republican colleagues are here, not because we don't say there is a problem, not because we don't have any ideas as to how to deal with the problem, not because we don't want to join hands with our friends across the aisle to solve the problem but because we know this bill is the wrong solution. Our constituents are pleading with us. They know this bill is the wrong solution. Every poll shows that. They are pleading with us: Don't let it happen. Don't let it happen. No matter what you have to do, don't let it happen.

It may well be that all our efforts are in vain. It may be we are washed aside in a tide of 60 votes. But we will not be washed aside by complacency or the desire to get along because the stakes are too high.

I conclude with this one last analogy. There was another very large organization that handed out a large series of entitlements to people with whom it was connected. These entitlements were not directly involved with the business of that organization, but they got bigger and bigger and bigger, and, ultimately, this organization suddenly discovered it could not function because of the financial drain of the entitlements it faced. The organization is now owned by the Federal Government. It is called General Motors. They discovered they could no longer be a car company because they were buried by the kind of entitlements they had built into their own situation.

Let us take a lesson from General Motors. We do not want the Federal Government to go bankrupt the way that company did. If we do, there is no other organization to bail us out the way the U.S. Government ultimately felt forced to bail out General Motors. It is a cautionary tale we all need to heed.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Thank you, Mr. President.

I, too, rise to voice my very strong concerns about this latest version of so-called comprehensive health care reform. I will speak of my strong concerns starting with the process we are in the midst of because I am still digesting the particulars of this latest megabill.

As you know, it was divulged yesterday, a 383-page amendment to the underlying bill. The amendment references another bill which is 286 pages. The underlying bill is 2,074 pages. It makes for the seventh—count them—the seventh version of so-called comprehensive health care reform, Obamacare for short, in a few weeks. That grand total would be 2,733 pages. So, certainly, I am still digesting this latest version. My staff is helping me,

but I wish to rise to begin to express my concerns.

The first concern is what I just referenced, this process we are in the midst of. When I went around Louisiana and when I continue to go around Louisiana—have townhall meetings—of course, health care comes up first and often. The themes I hear over and over are: This is too important to rush. This is too important to have some arbitrary deadline, whether it was last summer or Christmas. We need to get it right, not have arbitrary deadlines, and we need to know what we are voting for or against. That is what I hear about the right process to use over and over and over.

Well, unfortunately, clearly, this process we are in the midst of does not honor those wishes of Louisiana citizens, of American citizens. Before this latest megahealth care bill was unveiled yesterday, everyone it seems—including Members of the majority party who, at least, were involved in the negotiations, unlike Republicans—was in the dark.

Let me mention a few statements Democratic Senators made over the last week or so before yesterday's unveiling.

Senator DURBIN, in the leadership, said:

> I would say to the Senator from Arizona, that I'm in the dark almost as much as he is. And I'm in the leadership.

Senator SCHUMER of New York, also in the leadership:

> I can't say what there is, because we're not allowed to talk about what's submitted to CBO.

Senator BAYH of Indiana:

> We're all being urged to vote for something and we don't know the details of what's in it.

Senator BILL NELSON of Florida:

> I don't know what the deal is.

My colleague, Senator LANDRIEU, of Louisiana:

> There's no specific compromise. There were discussions. . . . Until the package that was sent is scored, we really don't even know what's in it.

Senator CASEY of Pennsylvania:

> Any big agreement is progress . . . even if we do not know any of the details.

Senator FEINSTEIN of California referred to a meeting on the majority side recently:

> There was no explanation. It was sort of go team, go.

Senator BEN NELSON of Nebraska, talking about a similar majority meeting:

> General concepts, but nothing very specific at all.

Then, at least yesterday, this new megabill—this 383-page amendment, referencing another 286-page bill, attached to an underlying 2,074-page bill—was unveiled. That finally happened yesterday morning.

Well, that is some progress. But I am afraid it is not progress enough. It is not time enough, considering we are set to vote on this new megabill in just a few hours, starting at 1 a.m. tomorrow morning.

Listening to American citizens all over the country, several Senators, including myself, have advocated we need at least 72 hours of final bill text on the Internet before we take any votes about this sort of major legislation. We need at least 72 hours of the official Congressional Budget Office cost estimate being on the Internet before we start any of those votes. I have certainly advocated that. Many of my colleagues on the Republican side have advocated that, listening, responding to American citizens who say: No arbitrary deadlines. Know what you are voting on. Get it right.

Perhaps even more importantly than my advocating it or other Republicans advocating it, at least eight Democrats have specifically demanded the same thing. In fact, on October 6 of this year, eight Democrats wrote a very clear, strongly worded letter to the majority leader, Senator REID, and they demanded exactly the same thing: 72 hours of final legislative language on the Internet before any vote on the matter, a full Congressional Budget Office cost estimate on the Internet for at least 72 hours before any vote on the matter. I applaud these Senators for demanding that: Senator LINCOLN, Senator LANDRIEU, Senator MCCASKILL, Senator PRYOR, Senator BAYH, Senator LIEBERMAN, Senator BEN NELSON, and Senator WEBB.

But, again, this process we are in the midst of certainly does not honor that minimal demand. We are set to vote on this in just a few hours. When we do, we will have only had the final legislative language for about 40 hours. We will have only had the full Congressional Budget Office cost estimate for about 37 hours. That is 56 percent or less of this minimum timeframe that so many of us, including eight Democrats, have demanded.

Again, this rush to judgment, this rush to beat an arbitrary Christmas deadline, is clearly ignoring the common sense of the American people, the common sense I heard in my dozens of townhalls all across Louisiana: no arbitrary deadlines. Know what you are voting on. Get it right. Do not rush to judgment.

I have strong concerns about this process. Where are the 72 hours? Where is the opportunity for Members and the American people to know what is in this latest version of a megabill on so-called comprehensive health care reform? Where is the 72 hours' notice of a Congressional Budget Office cost estimate?

Given that rush to judgment and arbitrary timeline, I am rushing to digest this latest version of the bill. But certainly, already, I have other very strong substantive concerns. I will be coming back to the floor within the next few days to more precisely outline those concerns as I digest more of the details of this latest megabill. But let me mention at least six of the big Louisiana-based questions I am focused on in terms of this latest megabill, this latest so-called comprehensive health care reform or Obamacare.

No. 1 is the impact on the Louisiana State budget. There has been a lot of discussion about that because of the particular language included in the bill pertaining to Louisiana that apparently gives Louisiana a $300 million benefit. The problem, from the Louisiana perspective, is in the Medicaid system, and that $300 million is directly related to Medicaid. In Medicaid, there is a much greater additional burden put on all States, including Louisiana. In Louisiana's case, apparently, that is going to far surpass $300 million.

So I am concerned about the overall, the net, impact on the Louisiana State budget, particularly because of the dramatic expansion of Medicaid. Medicaid is the health care program for the poor. It is dramatically expanded in the bill. Every State—except perhaps Nebraska because of special language put in for Nebraska—every State pays a match for both existing Medicaid and Medicaid expansion. That is going to put a big extra burden on the Louisiana State budget, and that big extra burden is apparently going to be much more than the $300 million of benefit that has been so widely talked about. I am looking, right now, at the details of that.

My second big Louisiana-based concern has to do with the Louisiana seniors—Louisiana seniors who have paid into Medicare, the health care system for retirees, for years and have assumed it would be there for them, as they paid in, as they followed the rules every step of the way. I know from the study I have done already that this new, latest version of the megabill, so-called comprehensive health care reform, involves a $464.6 billion cut to Medicare. That is going to impact every Louisiana senior, and it is going to impact tens of thousands of Louisiana seniors on Medicare Advantage particularly onerously.

My third big Louisiana-based concern is the Louisiana taxpayer because this bill contains massive tax increases to pay for all these new entitlements. Apparently, the total figure of tax increases in the bill is $518 billion—over $½ trillion—more tax increases than in any of the six previous megabills, the six previous versions of Obamacare. A lot of these taxes are clearly going on individuals who earn less than $200,000 per year, families who earn less than $250,000 per year. A lot of Louisiana taxpayers are going to be hit. That is a big concern.

Fourth, I am concerned about Louisianians who have health care now and who pay premiums because those premiums, by all accounts, by all independent estimates, are going to go up because of the taxes and fees and other burdens in this bill.

Fifth, what about Louisiana small businesses, businesses that are struggling right now in a serious recession, the most serious recession since the

Great Depression? We are in the midst of an extremely serious recession, and we are putting new mandates, new burdens, and new taxes on Louisiana small business. By all accounts, that is going to cost jobs, pure and simple, as we are in the midst of a very serious recession. I am concerned about that impact on Louisiana small business.

Sixth, and finally, Louisiana defenders of life. I am very proud to say Louisiana is one of the most pro-life States in the Nation—very strong values which hold up life and the defense of life in all its forms. Apparently—it is clear to me—this bill has taxpayer funding of abortion, the first time ever in Federal legislation, breaking tradition from the Hyde amendment, which has been the law since early 1977.

I am very concerned about that radical, truly radical departure from the past.

So in closing, let me say I hope we can adopt a different process, one that reflects the common sense of the American people and Louisianans when they say no arbitrary deadlines, no rush to judgment, and know what you are voting on. Also, I hope we will adopt a different approach that doesn't involve all of the downside I have mentioned, those six major categories.

I am still digesting this latest megabill. I will return to the Senate floor in the next few days to talk more and in more detail about those concerns I have laid out. But I hope all of my colleagues, Democrats and Republicans, look hard at those and similar concerns, look hard at the process and resolve to not just do this quick, not just do it before Christmas by some arbitrary deadline, but to do it right and to honor the American people in our work.

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

The PRESIDING OFFICER. The Senator from Florida.

Mr. LEMIEUX. Mr. President, I am new to this Chamber, and as I have sat here today and listened to my distinguished colleagues speak about this bill, watching some of my other colleagues on television in my office this evening, I can't help but think how fortunate I am to be here, to be a part of this process. It makes me think back also to the Founders who put together this great constitutional system of democracy that we have in this country, with the three branches of government, and here in the Senate, the sober and reflective legislative body that thinks through the great issues of the day to make sure we get them right for the American people.

In listening to this great debate, I wonder what they would think about what we are doing here. Putting aside the substance, what would they think of the procedure? Because I am new to this Chamber, I think I still have fresh eyes as to what is normal as compared to perhaps what is a little bit departed from normal. Would they think it was within their intentions as the Founders that we would be coming here to vote at 1 o'clock in the morning? Would they think it would be within their intention of how things would work in the Senate that we would get an amendment to the bill that is 400 pages long, we would get it yesterday and would have just a little time to consider it before we try to vote on it? Would it be what they intended, that we would press this vote up against Christmas, and we would try to get it done quickly while most of the people in our country are off with their families and preparing for the holidays? Would that be what they intended, the process of this great deliberative body, arguably, it is often said, the greatest debating institution in the world? Is that the way they would want us to achieve policy that is going to affect one-sixth of our economy? I don't think so. In fact, I don't think the American people think so either.

That is why they are so bewildered as to what we are doing here in the Senate and why we are, as my friend and colleague from Louisiana said, rushing to judgment; why we must get this done before Christmas. If it is such a good bill, why do we have to get it done so quickly? If it is such a good bill, why can't we take some more time to evaluate it? If it is such a good bill, why can't we offer more amendments to it?

So I am sure the American people, if they are home watching this—and they are probably watching Sunday night football—but if they are watching this, they would say: Of course, my Senator from Florida or the Senators from the other States can now offer amendments to try to improve the bill. But that is not the case because the leader of the Democratic Party, the majority leader, has done something called filling the tree.

Now, look, I am new here, too, so this is all new to me, but it is a process by which no other amendments are allowed. So if we want to change the bill, if we have ideas to improve it, that is not allowed. Is that what the American people want from us? Is that what our Founders intended? I don't think so.

So we have this new amendment. It is 400-some pages long. I guess it is the amendment to fix the problems that were in the bill, or at least to get 60 votes. And what do we know about this amendment? What does it do, for example, to Medicare cuts? We know the previous bill before the Senate cut nearly $½ trillion out of health care for seniors. What does this amendment do? Well, it still cuts health care for seniors. It actually cuts a little bit more, but it is still around that same number: $½ trillion.

We know also that it raises taxes. Does it raise taxes $½ trillion as the previous measure did? Yes, it does. In fact, it raises taxes a little more. Now it is $518 billion.

Well, what about the question that is the most pressing on the minds of most Americans, the very reason we are here, according to the President of the United States, which is to impact the cost of health insurance for most Americans. What does it do about that? Does the amendment do something about that? We know the underlying bill does nothing to impact the cost of health insurance for most Americans. We are here about to change one-sixth of the U.S. economy, and this bill does nothing to impact the cost of health insurance for folks who already have health insurance in this country. That is not me saying it; that is the Congressional Budget Office.

If you are one of the 170 million Americans who already have health insurance, this bill is not going to lower your costs. In fact, for some Americans, it is going to increase your costs over the next 10 years.

Well, does this amendment fix it? No. So we are still in the same situation—cutting $½ trillion out of health care for seniors, raising taxes by $½ trillion, with nothing in it for most Americans in terms of the cost of their health insurance.

How is this going to affect the American people? Well, if you have Medicare, if you are a senior who has been paying into it, it is going to affect you.

My friends on the other side of the aisle will say: Look, the nearly $½ trillion that we are going to take out of Medicare is just waste, fraud, and abuse. We will get that money out. Well, the Congressional Budget Office says the measures that are in the bill will take out $1½ billion worth of waste, fraud, and abuse, not $500 billion. So where is the rest going to come from? It is going to be decreased benefits. It is going to be decreased access to doctors.

We know right now in Medicare, nearly 24 percent of medical health care providers—your doctors, for example—will not take Medicare anymore, 24 percent, one in four of them. In Medicaid it is 40 percent.

What is going to happen when you reduce the amount of money you are paying into Medicare? You are going to reduce the amount of money that is being paid to providers, which means providers are not going to see their patients. If the doctor is not in, it is not health care reform.

This really impacts my State of Florida. We have the highest number of seniors per capita, 3 million seniors, on Medicare, and they are going to be impacted.

I wish to read from a letter that was sent to me by Mr. Richard Mullaney. I received it at the end of November. It says:

> Dear Senator LeMieux. I thought you might like to see this letter I received from my cardiologist.

It attaches that letter from the Palm Beach Cardiovascular Clinic in Jupiter, FL, down in southeast Florida.

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

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

PALM BEACH CARDIOVASCULAR CLINIC,
Jupiter, FL.

AN OPEN LETTER TO OUR PATIENTS: The 2010 Medicare Fee Schedule mandates that on January 1, 2010 severe cuts in cardiology physician fees will begin. This cut is being phased in over four years because the government used flawed data to make their calculations. In addition, there are Congressionally mandated cuts of more than 20 percent to all Medicare physician fees, regardless of specialty. The result of these combined government policies are that our practice is facing payment cuts ranging from 25 to almost 50 percent.

Such drastic reduction in fees are going to seriously hamper our ability to continue to see you, our patients, as we do today. We feel the need to warn you that these reductions will translate into much longer waiting periods for you to schedule an appointment or a procedure with your doctor, longer telephone response times to you, and not having the convenience of in-office Nuclear and Echo diagnostic testing available to you. Making sure you have the best quality of care will always be our number one priority. Caring for people is why we all dedicated our lives to heart patients. In the very near future—it is going to be a difficult climate to operate in our current manner.

We have built our office facility and trained our staff to best take care of each patient. We believe that the care you receive is critical to your quality of life. Wish these cuts we may not be able to provide some of the services that patients have come to depend on and in the long run; if the current policies are not changed, we may be forced to close our doors.

As a cardiovascular patient we urge you to contact our lawmakers (see attached for their information) about the impact of our changing practice on you. The law is clear—we face cuts unless Congress acts. In advance we thank you for understanding our changing environment.

Sincerely,

GABRIEL E. BREUER.
CHAUNCEY W. CRANDALL IV.
AUGUSTO E. VILLA.
AGUSTIN A. VARGAS.
GONZALO J. LOVEDAY.
BURTON H. GREENBERG.
SIDNEY M. RICHMAN.

Mr. LEMIEUX. Mr. President, it is an open letter to patients, and it is signed by some seven doctors who are in this cardiovascular clinic practice. I will read portions of it. It says:

Drastic reduction in fees are going to seriously hamper our ability to continue to see you, our patients, as we do today. We feel the need to warn you that these reductions will translate into much longer waiting periods for you to schedule an appointment or a procedure with your doctor, longer telephone response times to you, and not having the convenience of in-office Nuclear and Echo diagnostic testing available to you.

The letter goes on to say:

With these cuts we may not be able to provide some of the services that patients have come to depend on and in the long run, if the current policies are not changed, it may force us to close our doors.

So these are doctors, real doctors, and this is a letter from their real patient saying: If these cuts to reimbursements to doctors and providers aren't addressed, then we are going to have an inability for doctors to perform health care.

Those are real-world problems that are going to occur if this bill is passed.

So this is no great shakes for seniors. This isn't health care improvement for seniors. Those that we already have on a government entitlement program, those who have already paid into the program are going to have a cut in their benefits. That is exactly what the Chief Actuary, we found out last week from the Center for Medicare and Medicaid Services, said. He said it is plausible, even probable, that there will be shortages for Medicare and Medicaid beneficiaries because there is not going to be doctors who are available to see them.

Let's talk about the taxes: $518 billion in tax increases. What is that going to do to the cost of health care? We are going to tax medicine. We are going to tax lifesaving devices. Those taxes, of course, will be passed along to you, the consumer. So for you, your cost of health care will go up, taxes on health insurance of almost $60 billion; taxes on medical devices, $19 billion; taxes on medicine, $22 billion. If you don't have health insurance now and you don't get it, you will be taxed. If you are a small business and you don't provide health insurance to your employees, you will be taxed.

I had a telephone townhall meeting this week, and I talked to a gentleman from central Florida who had been laid off from his job at a restaurant. He said to me: The reason I got laid off is because the restaurant couldn't afford the health care benefits. So when health care benefits went up, the restaurant raised its prices for its food, people stopped coming to the restaurant, and the restaurant went out of business. Then there wasn't health care for any of the employees.

You can't get blood from a stone. While the benefits of this plan as laid out by my Democratic colleagues may sound great—33 million more Americans who are going to have some kind of health insurance—you have to look at the details. How are you going to pay for it, and what is the effect going to be? When you raid nearly $½ trillion out of Medicare, you are going to decline the quality of health care for our seniors. When you raise taxes by $½ trillion, you are going to pass those costs along to consumers who already have health insurance, and their prices are going to go up. You are going to pass them along to small businesses that would not be able to afford them, that will let people go.

We have 11.5 percent unemployment in Florida. When small businesses can't afford this, they are going to let people go or, like that restaurant, close their doors. That is not good for a country that is fighting through the worst recession since the Great Depression.

Now we find out there are a bunch of special deals in this bill. We find out that the Senator from Nebraska has been able to get a special fix for his State.

See, another thing this bill does is it puts a big unfunded mandate on the States. What do I mean by that? An unfunded mandate is a requirement that the States must fulfill that they don't get paid for. This time it comes in the form of Medicaid, which is health care for the poor. Medicaid, under this proposal, is going to be increased. We are going to put 15 million more Americans into Medicaid.

If you think Medicare recipients are having a tough time finding a doctor, in Medicaid, 40 percent of health care providers will not take it; 50 percent of specialists will not take it. Now we are going to put 15 million more Americans into it.

What it does to the States, in a State such as Florida, it is going to cost us in 10 years nearly $1 billion to accept this unfunded mandate. The Senator from Nebraska apparently got a fix for this so his State would not have to pay the $1 billion. Well, Florida would like that same fix. If it is good for Nebraska, it is good for Florida. I am sure Iowa would like that fix as well. I am sure all the States would.

So I ask unanimous consent that the pending amendment be set aside and it be in order to offer an amendment to extend to the State of Florida the same benefits that provide 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Objection.

Mr. LEMIEUX. For the folks who are watching at home, the reason my distinguished colleague from Iowa objected to this is because this deal would not go through if they provide it for every State. So some States are going to get it better and some States are going to get less, and that is not fair. But that is the process that has put this bill together, to cobble together 60 votes.

So at the end of the day—may I ask how much time I have remaining?

The PRESIDING OFFICER. Fifteen seconds.

Mr. LEMIEUX. At the end of the day, I have 15 seconds left. I will be back to the floor to speak about this again. But this is not a good bill for America, and that is why my colleagues on this side of the aisle have been debating and showing our objections so the American people can understand.

I yield the floor.

The PRESIDING OFFICER. The Republicans' block of time has expired.

The Senator from Massachusetts.

Mr. KIRK. Mr. President, I rise to, first, commend my distinguished colleagues, Majority Leader HARRY REID of Nevada, Senators BEN NELSON of Nebraska, BARBARA BOXER of California, BOB CASEY of Pennsylvania, and CHUCK SCHUMER of New York for the principled and practical compromise they reached on the difficult issue of abortion. Their work allows the U.S. Senate to now march with our House colleagues toward the forward edge of history and the enactment of The Patient Protection and Affordable Care Act, and I congratulate them for that important contribution.

I would also like to commend my colleague, the assistant majority leader, DICK DURBIN of Illinois, for bringing to the Senate's attention during yesterday's debate an op-ed that appeared in the Washington Post this morning written by our dear friend Victoria Reggie Kennedy entitled ''The Moment Ted Kennedy Would Not Want to Lose.''

Vicki Kennedy was Senator Kennedy's partner in all things, including his final efforts to move health reform forward even as he valiantly fought his own battle with cancer.

In more than 17 years of marriage, Ted and Vicki were inseparable, bonded by the love of friends, family and most obviously by their love for one another. Vicki displayed inspirational grace in leading us all in our grief and in the memorable celebration of his life on the occasion of Senator Kennedy's death.

And today, she continues as his partner paying tribute to Ted's legacy by respectfully urging his colleagues to move forward on the health reform he would have wanted.

I feel certain that Vicki's voice and his will make us more determined than ever to complete Ted's work for the American people. We thank you, Vicki.

Mr. President, I would now like to respond to an argument made in another op-ed in Thursday's Washington Post and in an interview on ''Meet the Press'' this morning by my friend, and a former Democratic Party chairman, Howard Dean.

Chairman Dean said in his opinion piece: ''If I were a Senator, I would not vote for the current health-care bill,'' because it does not bring ''real reform.''

With all due respect, before anyone swallows Howard's faulty prescription, as they say in the field of health care, ''It's time for a second opinion!''

As a former national chairman of the Democratic Party myself, I'll take my equal time to offer my opinion and say I am a U.S. Senator, and I will vote for the current health care bill precisely because it does bring ''real reform.''

Is it all the reform for which our friend and colleague Ted Kennedy, ''the Father of Modern Health Care Reform'', fought so valiantly and tirelessly throughout his legislative career? No.

Is it all the reform for which I and many of my distinguished colleagues advocated so passionately here on the floor of this Chamber throughout this intense debate? No.

But, is it a quantum leap forward that will bring ''real reform'' to a broken, discriminatory, bankrupting, deficit-busting health care system that will only get worse without immediate action and passage of this legislation?

The answer is clearly: Yes.

One of the reasons history will record that Ted Kennedy was the greatest legislator of our time was that he respected the need and the art of compromise.

And he would argue that a choice between a solid, sound, significant and long overdue start at ''real reform'' of our health care system and the choice of leaving American families to continue to fall behind because we refused to seize the historic moment before us—is the easiest choice and, perhaps, the most historic vote we may ever cast as U.S. Senators.

Does anyone in this Chamber—or in Massachusetts—or anywhere else for that matter, doubt Ted Kennedy's commitment to legitimate, credible, real reform of our system in order to make affordable, quality health care accessible to the greatest number of Americans? The answer is clearly: No.

Is this a bill of ''real reform'' that Ted Kennedy would champion and vote for? Absolutely, yes!

Ted Kennedy knew real reform when he saw it, and so do I.

Here are the real health care reform measures of this Senate bill, many of which Senator Kennedy helped to craft. Think about this.

It will save money and save lives; expand coverage and bring over 30 million uninsured Americans into the community of the insured; It will control costs and lower premiums; stimulate competitive choices so consumers can choose the best policy at the most affordable price; relieve the costly health care burden on the small businesses of America through tax credits; provide a discount to countless seniors like my own sister Maud, who are squeezed by the cost of prescription drugs under Medicare D's so-called doughnut hole.

The real reforms in this bill will strengthen Medicare and Medicaid; reduce the deficit by hundreds of billions of dollars; attack waste, fraud and abuses; eliminate lifetime limits on needed care; reward wellness and preventive practices; increase transparency and insurance company accountability; promote flexibility, innovation and best business practices; reward the quality and value of care instead of the quantity and volume of procedures.

This bill will eliminate unjust discrimination against women or those afflicted with preexisting conditions; it will provide the elderly and disabled a voluntary choice to self-fund a plan that will provide financial security to purchase long-term services when they are needed most; it will require insurance companies to cover children and dependents up to age 26; and prohibit insurance companies from dropping coverage for Americans who get sick—the very reason they buy health insurance in the first place!

In these and many other ways, this Senate bill is real reform—for a senior citizen who cannot afford the drugs she needs; for the 31 million people who will now have the health insurance they deserve; for families who worry that hospital bills will wipe out their life savings; and for a system that presently fails to serve the needs of the American people, this is real reform.

For those well-meaning progressives who say they oppose this bill because it does not go far enough and to my colleagues on the other side of the aisle who want to defeat this bill and start over, I say they are both mistaken.

We need to win this fight now and we need to win this fight together! Will there be more to do after its enactment?

Mark my words. There will always be more to do. But this historic piece of legislation will be a giant step forward toward a health care system that truly begins to serve the needs of the American people.

President Kennedy offered two profound observations that have helped me keep things in perspective throughout my life, and they have particular application at this moment in our time. He once said:

> Wisdom requires the long view.

And on another occasion, he said:

> Democracy is never a final achievement; it is a call to an untiring effort.

John Kennedy's words apply so well to the work of health care reform before us this evening and to the legislation that will pass this Senate within the next several days.

We are all called upon to exercise our wisdom and to take the long view of history. We must understand that passage of this legislation will not be a final achievement. It will be a compelling first call to an untiring effort to continue with our responsibility to do what the American people deserve—provide affordable, accessible, quality health care for them as a matter of right.

I am old enough to recall the Civil Rights Act of 1960, and the Civil Rights Act of 1964, and the Civil Rights Act of 1968. With the passage of each of those laws, there was always more to do. But each began the march of progress toward equality under our laws. And each created a responsibility to assure that our country's laws more aptly reflected our national character and our principle of equal justice.

The same is true of this moment in our national history. The bill before this Senate is not perfect, nor will it be the final product. But make no mistake, it is real reform, and it will provide enormous benefits to America's workers, America's seniors, and America's families.

I urge my Republican colleagues not to be held hostage by the raw and divisive politics of the moment, not to be the captives of those who may threaten with some meaningless political litmus-test score cards, but to step back and to think about the positive difference these reforms will make in the lives of the millions of American families you represent—and, finally, to reflect wisely upon the long view of history and decide that this is the moment to join the majority of this U.S. Senate in moving toward history's enlightened edge by voting for this landmark legislation.

I yield the floor.

The PRESIDING OFFICER. Who seeks time? The Senator from Connecticut.

Mr. DODD. Mr. President, before he leaves the floor, let me commend our colleague from Massachusetts, PAUL KIRK, who has only been with us a brief amount of time under circumstances he has said on numerous occasions over the last several weeks he would much prefer to have avoided. I commend him.

Many of my colleagues know that PAUL KIRK is no stranger to this institution, having worked as a member of the staff in Senator Kennedy's office for many years. He has had a distinguished career in his own right in Boston. We welcome him here under those very sad circumstances. But his remarks this evening are evidence of the value he has placed in coming to this Chamber and filling a gap here and articulating a view our colleague from Massachusetts would be expressing were he here these days and tonight.

Said so well, if it has not been printed in the RECORD, I ask unanimous consent to have printed in the RECORD an editorial piece written by Senator Kennedy's wife Vicki Kennedy.

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

[From the Washington Post, Dec. 20, 2009]

THE MOMENT TED KENNEDY WOULD NOT WANT TO LOSE

(By Victoria Reggie Kennedy)

My late husband, Ted Kennedy, was passionate about health-care reform. It was the cause of his life. He believed that health care for all our citizens was a fundamental right, not a privilege, and that this year the stars—and competing interests—were finally aligned to allow our nation to move forward with fundamental reform. He believed that health-care reform was essential to the financial stability of our nation's working families and of our economy as a whole.

Still, Ted knew that accomplishing reform would be difficult. If it were easy, he told me, it would have been done a long time ago. He predicted that as the Senate got closer to a vote, compromises would be necessary, coalitions would falter and many ardent supporters of reform would want to walk away. He hoped that they wouldn't do so. He knew from experience, he told me, that this kind of opportunity to enact health-care reform wouldn't arise again for a generation.

In the early 1970s, Ted worked with the Nixon administration to find consensus on health-care reform. Those efforts broke down in part because the compromise wasn't ideologically pure enough for some constituency groups. More than 20 years passed before there was another real opportunity for reform, years during which human suffering only increased. Even with the committed leadership of then-President Bill Clinton and his wife, reform was thwarted in the 1990s. As Ted wrote in his memoir, he was deeply disappointed that the Clinton health-care bill did not come to a vote in the full Senate. He believed that senators should have gone on the record, up or down.

Ted often said that we can't let the perfect be the enemy of the good. He also said that it was better to get half a loaf than no loaf at all, especially with so many lives at stake. That's why, even as he never stopped fighting for comprehensive health-care reform, he also championed incremental but effective reforms such as a Patients' Bill of Rights, the Children's Health Insurance Program and COBRA continuation of health coverage.

The bill before the Senate, while imperfect, would achieve many of the goals Ted fought for during the 40 years he championed access to quality, affordable health care for all Americans. If this bill passes:

Insurance protections like the ones Ted fought for his entire life would become law.

Thirty million Americans who do not have coverage would finally be able to afford it. Ninety-four percent of Americans would be insured. Americans would finally be able to live without fear that a single illness could send them into financial ruin.

Insurance companies would no longer be able to deny people the coverage they need because of a preexisting illness or condition. They would not be able to drop coverage when people get sick. And there would be a limit on how much they can force Americans to pay out of their own pockets when they do get sick.

Small-business owners would no longer have to fear being forced to lay off workers or shut their doors because of exorbitant insurance rates. Medicare would be strengthened for the millions of seniors who count on it.

And by eliminating waste and inefficiency in our health-care system, this bill would bring down the deficit over time.

Health care would finally be a right, and not a privilege, for the citizens of this country. While my husband believed in a robust public option as an effective way to lower costs and increase competition, he also believed in not losing sight of the forest for the trees. As long as he wasn't compromising his principles or values, he looked for a way forward.

As President Obama noted to Congress this fall, for Ted, health-care reform was not a matter of ideology or politics. It was not about left or right, Democrat or Republican. It was a passion born from the experience of his own life, the experience of our family and the experiences of the millions of Americans across this country who considered him their senator, too.

The bill before Congress will finally deliver on the urgent needs of all Americans. It would make their lives better and do so much good for this country. That, in the end, must be the test of reform. That was always the test for Ted Kennedy. He's not here to urge us not to let this chance slip through our fingers. So I humbly ask his colleagues to finish the work of his life, the work of generations, to allow the vote to go forward and to pass health-care reform now. As Ted always said, when it's finally done, the people will wonder what took so long.

Mr. DODD. Mr. President, she said it very well, as Senator KIRK has, that this is far from a perfect bill. We all know that. It is far from a finished product in terms of health care. The Presiding Officer spent a good part of his career as well working on this issue and would be the first to acknowledge as well that we have a lot more work to be done.

Congresses long after all of us who serve in this Chamber are gone will be grappling with the issue of how we can better deliver health care services, create greater access, and reduce the cost of health care while extending quality of life for our fellow citizens and removing the fear so many families feel when they discover that a loved one—a child, particularly—is suffering from some illness or disease that requires attention and yet to be informed that the costs of providing that attention, that care is so prohibitive that they cannot afford to do it and wondering why they, because they lack the economic circumstances, cannot take as good care of their children as someone with access to greater economic power can.

That is what we are trying to achieve, to create that availability. I don't know anybody who disagrees with the statement that health care in America ought to be a right, not a privilege. And if it is a right—then, just as other rights are extended to every citizen regardless of their economic circumstances, their ethnicity, their background, their gender, certainly this right ought to be no different in that regard and available to all of our fellow citizens regardless of their financial circumstances. That is what we are starting to do here. It does not achieve that goal perfectly, but it puts us on that path to achieving that equity, that ability for families and individuals to take care of themselves and their families when afflicted by a medical crisis or medical problem.

Having been deeply involved in this issue now for not quite a year but almost a year, since it became very difficult for my friend and colleague from Massachusetts to conduct the kind of daily and hourly efforts he would have been involved in but for his health condition, we have come to a moment now to decide whether we go forward, whether we accept the responsibility as being Members of this body to do the best we can when trying to design something written by 100 people, not to mention 435 in the other body, not to mention an administration and all of their interests, not to mention all of the stakeholders who are involved in health care, which is so voluminous that it would be impossible, even in the time remaining this evening, to mention everyone who has a stake in the outcome of this discussion.

Taking all of those elements and trying to bring them together to fashion an ideal or set of ideas to go forward has defied, as I have said on so many occasions in this Chamber over the past number of months, has defied every administration and every Congress since this first challenge was posed by—well, going back to the days of Theodore Roosevelt but more recently since the time of Harry Truman. Every Congress, Republican and Democratic, every President, Democratic and Republican, has at least thought about doing this. Some have actually tried. President Nixon actually tried. President Clinton actually tried to come forward. Those who remember those days, for a variety of reasons, some that seem more clear today than the hour they were being debated, those efforts failed. We are now that third administration, that third effort that has come this far, if you will.

My hope is that this evening and in the ensuing few days, we will complete our task in this body and continue the effort by working with the House of Representatives to fashion a final product for the signature of the President of the United States to allow us to begin what will be a long journey to make sure that right of health care is available to all of our citizens.

Many of us here may never see the benefits of that just because of life expectancy, I suppose. But to know you are leaving a health care system in place for the coming generation where they can look back on these wintry days in the Senate and be reminded that there was a Congress at the outset of the 21st century willing to face up to the challenges, with all of the accusations, all of the barbs, all of the ad hominem arguments hurled at people, and make an effort to correct a wrong, to right a wrong, to make a difference and improve the quality of life for all of our fellow citizens—that is something I hope coming generations will recognize as a result of the efforts we have made here.

Let me take a few minutes to wrap up this part of the debate with my views as to where we stand at this hour.

When this body began the process of writing health care reform over a year ago, we knew it would represent a mammoth undertaking, and we knew it would get more difficult as we got closer to the goal line, as every major effort I have been involved in for three decades here has certainly evidenced. As you get closer to the goal line of major undertakings, it gets harder and harder to cross that finish line.

This issue involves one-sixth of our economy, affects 100 percent of our fellow citizens, and has been the center of American public policy debate since before many of us were even born.

Our path has been long and winding and has been difficult. It has been illuminated by a torch lit long ago in the days of Harry Truman and those who even preceded him and sustained for decades by very good people—Democrats, Republicans, and others—who believe that in a nation founded on freedom and sustained by unimaginable prosperity, no one—no one—in our country ought to have to go to sleep on a night such as this feeling that if they get sick or a loved one does, they will go broke or, worse, be unable to afford the care they or that loved one needs to get well.

As I said so many times before, the person who carried this torch as long and proudly as anyone since this debate began so many years ago is not here with us tonight, but he is here in spirit and good conscience. I speak, of course, of our colleague from Massachusetts, Ted Kennedy. He never expected that he or we would cure all our ills in one fell swoop, in one massive bill that would, once and for all, right this problem of health care. Progress, he would argue, is hard, and the simple mathematics of the Senate make it harder all the time.

I know our Republican leadership has basically advised their fellow members of their caucus not to vote for this bill no matter what is in it. I regret that. I think it is a sad moment but one with which we have to grapple. We cannot quit because of that political conclusion. We have to move forward. In fact, they went so far as to write a playbook for how to disrupt, delay, and obstruct progress on this issue. I know they do not like the bill and many parts of it. I also know many of them like many parts of this bill, and they acknowledge that when they talk about greater access, cost reductions, and the quality of health care. As one who conducted the hearings and the markup on health care over the last year, I heard over and over that members of that committee, Republicans and Democrats, speak of the very same goals we all seek with health care reform. I know, as a matter of fact, that many of them wrote major provisions of this bill. This bill is not devoid of the involvement and participation of members of the minority party this evening as we come close to voting on a final choice. But I regret it has come to that. I think our best efforts do emerge when we work together as citizens of this great country, regardless of the political labels we bear.

My hope will be in the coming days that those doors may open and participation may, in fact, flow and we will end up with a product coming back from conference that is even stronger than the one we are being asked to make a decision on this evening.

Someday we will look back on this moment in our Nation's history, and many of those not part of this decision will wish they stood in the arena instead of lobbing rhetorical grenades and cheap shots at a bill that deserves so much better. There is still time for my colleagues to stand and do what is right. I hope they will before the process is over.

As it is, our caucus had to work at finding compromise language we could all stand behind, and we have tried to do that over these days. The resulting bill is not one that any one of us would have written on our own given that opportunity. And that goes for me as well, as I know it does the Presiding Officer. We have fought for a strong public option in our committee. I fought to have it included in the bill the majority leader brought to the floor, and I would have happily been fighting for it even today given that opportunity. But as I have said, it is always easier to envision the legislation you want than to pass the legislation we can get.

Our country badly needs this legislation, even as imperfect as it may be in some aspects. The preferred outcome of our Republican friends we have in the Senate—deadlock within our caucus and a resulting failure to pass a reform bill—will result in more family bankruptcies, more deficits, and, sadly, more deaths that could have been prevented if everyone had access to decent health care. We do not have to let that happen. In fact, we will not let that happen. We have to be better than that.

Yesterday, the majority leader offered a managers' amendment to the original Patient Protection and Affordable Care Act which we have been debating since prior to Thanksgiving.

It toughens accountability policies for insurance companies, requiring them to spend more on health care and less on administrative costs and profits, holding them accountable for jacking up premiums, and prohibiting them from excluding coverage of preexisting conditions for children, effective immediately.

It provides American families with more health care choices, guaranteeing that in addition to a variety of private sector options, families can choose from at least two national plans similar to the ones we receive right here in the Senate, one of which will be a not-for-profit plan.

It strengthens affordability provisions in the bill, starting a tax credit for small businesses in 2010, giving families more information to shop for better deals, and helping to spread cost-saving innovations across the country.

It builds on the bill's protections for seniors, children, rural communities, and other vulnerable populations.

It preserves the bill's core commitments that no American should go broke because they get sick and no American should die because they cannot afford the care they need to get well.

After more than a year of legislating and more than 60 years of hard work on the part of advocates across the Nation, we have an unprecedented opportunity, both later this evening as well as the remaining days of this week. We are standing on the floor of the Senate with a chance to pass legislation that puts our focus on preventing disease, not just treating it, a bill that insures those 31 million of our fellow citizens who today lack any health insurance at all, a bill that guarantees every American access to quality health care at a lower cost.

Senator Ted Kennedy always believed we would someday have this chance, and I think he knew this year might be the best and for our generation the last chance. These opportunities do not come around very often. We fought for reform in the 1970s and failed. We fought for health care reform in the 1990s and failed as well. If we fail this time, if we let partisanship triumph over progress, if we lose sight of the goal in the face of political gamesmanship, we who stand here today may never get that other chance.

We came here to make this country a better place. I believe every person who serves here believes they came to the Senate to make our country a stronger and a better place. We have before us a

bill that saves lives, lowers costs, and frees tens of millions of our fellow Americans from the fear that grips them, as I address this Chamber on this evening. Let's do our jobs. Let's pass this bill. Let's make America stronger and a better place because this Congress and this administration rose to the challenge to grapple with a magnificent issue that deserves our attention and our support.

I urge our colleagues to support this bill.

I yield the floor.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Illinois.

Mr. DURBIN. Mr. President, let me first acknowledge the Senator from Connecticut, who played a critical role in not only the inspiration but the preparation of this important landmark legislation. Senator DODD has been given some tough assignments in his career. He has been handed some of the toughest, and this was one. His Health, Education, Labor, and Pensions Committee met, I understand, 54 hours, if I am not mistaken. I think that is what he said earlier on the floor. It considered hundreds of amendments with the notion that we could create a better, more effective health care system in America. I have yet to hear anyone criticize his chairing that committee. He was evenhanded and fair. He entertained and accepted some 150 or 160 Republican amendments to this bill in an effort to try to build some bipartisan support for it. He went the extra mile with extra hearings. His committee was weary at the end, but he proved that his experience in the Senate had taught him valuable lessons about what it took to be respectful to the other side of an issue. He was not rewarded with a final vote in committee. Not a single Republican Senator would vote for the bill. It was not for any lack of effort on the part of Senator DODD.

When this bill passes—and this bill will pass—he deserves special credit for it, and I am going to be one of the first to applaud him. He included a provision in this bill near and dear to me on congenital heart research that will save lives and will spare suffering to families across America. I will forever be indebted to him for it.

In just 4 hours, in the early morning hours of Monday, December 21, 2009, one of the most significant votes in the history of the Senate will take place. It is hard for us in the midst of this debate, after all that has come before us and all that is likely to follow, to properly put this in historical context. For those of us who were honored by the people of our State to be here at this moment in history, it is humbling to know we will be called on to cast a vote that can change a nation.

It has happened here before but only rarely. It happened 75 years ago when other Senators, in a much different era, battling through the worst depression in our Nation's modern history, were called on by a President in a wheelchair to rally and stand for the elderly of America. He asked to create Social Security, an insurance plan primarily for widows. President Franklin Roosevelt came to this Senate in this Chamber asking each and every one of the Senators to be mindful of the plight of our parents and grandparents in that time.

I can recall, in my family, it was not uncommon for grandparents to end up living in the same home as their children because after they reached the point where they could no longer work for a variety of reasons—physical, retirement, whatever it happened to be—their savings were meager and the chance of living independently was limited. So their children took them in in that spare bedroom, made them part of the family and welcomed, but understood that was the only way mom and dad were going to have the dignity they deserved in life.

Franklin Roosevelt had a different vision. He thought if workers throughout their worklife paid a little bit of money each week into a fund, they could be ensured there would be a check waiting for them at retirement that would allow them independence and dignity. He prevailed, and Senators stood up in that era of the 1930s and gave him the votes that were needed to change our Nation when it came to the way we treat the elderly.

Those on the other side of the aisle—Republicans—were skeptical. They were fearful of government; fearful of a new program. They argued we were headed down a path we would regret—echoes of many arguments we are hearing today in opposition to health care reform. When their time came later, even as recently as a few years ago, they tried to dramatically change and rewrite the Social Security Program. They called for privatizing it, saying we would be much better off if the Social Security trust fund were actually in the stock market. Thank goodness the wisdom of America rejected that idea. Within months of the suggestion, it was proven to be totally false, as life savings were lost with the recession that we now are enduring.

It is an indication of the bravery of a President, the courage of a Senate, and the fact that they rejected the pleas of those who would say: ''Do nothing. Don't touch it. Leave that problem alone.''

It was about 45 years ago when another great President had another great idea, and that idea was to create Medicare, and with the creation of Medicare to say to those same elderly: It isn't enough to give you a check to get by each month. We want to make sure you have access to doctors and hospitals when you need it. Lyndon Baines Johnson, the master of the Senate, then President, managed to engineer the passage of that legislation against critics who once again said: It is too much government. It is a program that will cost too much money. It is not needed. We shouldn't do it.

Their counsel was rejected. Medicare was created. It wasn't the Medicare we know today. It didn't reach the disabled. It didn't provide some of the basic services that many seniors now desperately need, and it didn't cover prescription drugs, but it was a start. It was a critical decision made to move forward. The same Republican Party that objected to the creation of Medicare has been critical of the program ever since. They have argued that it is wasteful, that it is doomed, that it should be allowed to wither on the vine. That was actually a quote from a leading Republican not that long ago.

They suggested there was a better way—let's privatize Medicare. They love the notion of privatizing. Get government out of the picture. They came up with this theory, with the health insurance industry, of something called Medicare Advantage. This was where those flinty-eyed entrepreneurs would teach government a lesson. They would offer the benefits of Medicare and show how to do it at a lower cost. Well, we accepted their challenge and gave them their opportunity, and what we found was: They failed. Oh, some succeeded, but by and large when the final count took place, those private insurance companies couldn't help but have the urge to maximize profits at the expense of Medicare. So now we spend about $17 billion a year out of Medicare subsidizing private health insurance under the so-called Medicare Advantage Program. The experiment has failed.

The basic idea of Medicare was proven right. It gave to our seniors something that we had promised and hoped we could deliver—longer healthier lives. It also triggered the creation of a medical health establishment across America—the building of hospitals and medical schools and more medical professionals than our Nation had ever seen—because of Medicare, because of a President, Lyndon Baines Johnson, and his courage, and because of a Senate that could rise to the challenge of passing it, despite the critics.

Well, in the early hours of Monday, December 21, 2009, our generation of the United States Senate will face our rendezvous with destiny, our opportunity to change this Nation, to make such a significant change in the way health care is delivered in America that we can say to future generations: We had our moment, and we seized it. To think that we will—with the passage of this bill in perhaps just a few days in the Senate, and a few weeks on Capitol Hill—enlarge the percentage of Americans with the security of health insurance from 83 percent to 94 percent—the highest percentage of Americans ever insured in the history of our Nation. Of 50 million uninsured Americans today, 30 million of those people will finally be able to rest at night knowing they are covered; that they have health insurance.

It will be Judy, a worker in Marion, IL, at a hotel, making $8 an hour, working 30 hours a week, $12,000 in annual wages. She is a diabetic. She has

never had health insurance in her life. She goes to work every day. She is 60 years old. She will have health insurance because of this bill. She will be covered by Medicaid, and she won't have to pay for it because Judy's wages are at the low end of workers in America.

I said to her: If you had health insurance, Judy, what would you do?

She said: Senator, I have a few lumps I have been worried about a long time, and I can't afford to go to the doctor. I would go to the doctor.

Thank God she can. Thank God for a lot of others—those who have lost their jobs, who are unemployed, who have exhausted their savings, who stand to lose their homes—who will at least have the peace of mind they will have health insurance. That is going to come too.

If you have a child with a health problem, as many people do, something they call a preexisting condition, this bill will tell the health insurance companies immediately: You can no longer discriminate against that child. You can't turn down the family or that child for coverage. As someone who has been through that experience, I can't tell you what that means, to know that you have that kind of coverage; that your child, with that health care challenge, can go to the doctor they need to see and the hospital they need to be in.

When my wife and I were first married and had our first baby, I was in law school, and we had no health insurance. When our baby had a problem, I had to go to Children's Hospital here in Washington and sit in a room filled with people who had no health insurance. I took a number, and we waited for a doctor. Every time we went, it was a different one. I felt like I had let my family down. At a time when my family needed health insurance, I had not delivered. I know that feeling personally, and I know what it must mean to 50 million Americans who face it today. For 30 million of those Americans, this bill will give them the peace of mind that they have health insurance.

It also says to companies across America, we are going to change the terms of this relationship between health insurance companies and the people they insure. We are going to finally step in on the side of the consumers of America—the families of America, the ones that are so often turned down because of preexisting conditions, turned down because companies canceled their insurance when they started running into high medical bills. For the first time, these people will have legal rights created by this bill to stand up and be covered and to be confident at the end of the day that they will have the coverage they paid for their whole life.

It is an amazing thing we are considering. In the middle of it, with all these speeches and all the press releases and all the charts and all the time, it is sometimes difficult to focus on the historical impact of what we are about to do at 1 a.m. on December 21, 2009. But if we do this, and do it right; if 60 Senators step forward, as I think they will—commitments have been made—we will make history. It will be reported across America that for the first time in memory, the United States Senate has voted for comprehensive health care reform.

The critics will still be there, and they will say the same thing they did about Social Security and the same thing they did about Medicare: It is too much government. It is not going to work. We shouldn't do it.

Thank God, that counsel was rejected in the 1930s and the 1960s, and it should be rejected on December 21, 2009. We need to stand together for people who otherwise have no voice—the uninsured, many of whom have low-wage jobs, or maybe no jobs at all, and their children, who really can't afford the best lobbyist in Washington. It is time for us to lobby for them.

I know there are a lot of critics of this plan. We have heard them. They have talked about Medicare and what this will do to this bill. But we know what the professionals have told us. This comprehensive health care reform legislation will add 9 or 10 years of solvency to Medicare, put Medicare on sound financial footing. And that is exactly what we should do.

The bill has a bonus. The bonus is that, at a time when we are facing deficits and debt, which have to be taken seriously, this bill charts a path for us to start retiring that debt. The Congressional Budget Office says that over the first 10 years, $130 billion in debt will be relieved by this bill; then in the second decade of this bill's existence and changes, we are going to find up to $1.3 trillion in deficit reduction.

There has never been a bill considered on the floor of the Senate that has had that kind of impact on our Nation's debt. It is going to change life not only for uninsured families but even those with insurance. For some, it will give the luxury that we have as Members of Congress.

I think we are the luckiest people on Earth when it comes to health insurance. We team up with 8 million Federal employees and their families, and each year we have an open enrollment. If we don't like the way we are treated by our health insurance company in the previous year, we can go shopping, just like you would shop for a car or a refrigerator, and pick the right one for your family. We pick the right health insurance for our families. Every American should have that luxury, and we move toward creating that in this legislation.

It was several years ago that I teamed up with Senator BLANCHE LINCOLN of Arkansas and Senator OLYMPIA SNOWE of Maine. We tried to create a program for small businesses in America called the SHOP Act. This program would give those small businesses the same shopping opportunities for health insurance as Members of Congress and Federal employees. I came up with an unlikely ally in the National Federation of Independent Businesses. They decided they wanted to join us.

When their lobbyist called and said he wanted to meet with me, I said: I can't wait to meet you. His organization had done everything in their power to defeat me in every election I had been in, and I wanted to see what he looked like.

He came in and sat down and said: We have to do something about health insurance for small business. We ended up creating an unlikely but powerful alliance of the National Federation of Independent Businesses, the realtors, the Service Employees International Union, Families USA—from both sides of the political spectrum—standing behind the SHOP bill.

The SHOP bill, with some changes, is now part of health care reform. It is an idea that has been endorsed, and it is one that I think is going to make a big difference for individuals. The bill also contains help for small businesses to pay for the premiums. Critics on the other side of the aisle say: Oh, the taxes go up, but the benefits don't start for years. They have missed it because initially we are going to be offering tax assistance to small businesses with 50 employees or fewer. Those who have an average payroll of $50,000 a worker are going to get a helping hand to buy health insurance not only for their workers but for the owner of the company.

I have seen this in my own life. I have friends who run a small business who have lost their health insurance because one employee's wife had a very sick baby. That is exactly what happened to my friend. They went out shopping for insurance on the open market and it was brutal. My friends were in their early sixties, and they couldn't buy insurance. Everything they could buy was loaded with exclusions and deductibles and copays.

Well, we are going to make sure that businesses have a helping hand with a tax credit, and that helping hand is going to allow them to buy good insurance that covers their employees.

Those on the other side talk about the tax increases in this bill. Let's be very blunt what they are. There is a .9 percent payroll tax increase for individuals making over $200,000 a year and families making over $250,000 a year. What it means is this: Roughly $2,000 a year for families making over $250,000 will have to be paid to make sure that Medicare is solvent and that this program is funded. That may affect some Members of Congress, with their spouses working. But I don't think it is unfair. It is a tax we should be willing to pay to solve major problems in this country.

There will be taxes on high-end health insurance policies, and it is a very controversial provision with some of my friends in organized labor. But I

hope we have hit the right number of $23,000 and I hope our escalator clause to try to keep up with inflation is a reasonable one. If it is not, we will revisit it. The only law ever written that didn't need amendment might have been the Ten Commandments, and I don't think this bill, as good as it is, will rise to that level. We are prepared to return to it if we need to, to make sure it works and works well, and we have the time to do that.

This is critical. I also know this bill is going to change—you will be able to see the change across America with the construction of community health clinics. One of our great Senators here, BERNIE SANDERS of Vermont, has been a clarion voice on behalf of community health clinics. He knows, as we all do, that these clinics, placed in cities and towns across America, are a lifeline to low-income people so that they have primary care at a fraction of the cost of a visit to an emergency room—good care. I have seen it. I have visited the Erie Clinic in Chicago, Alia Clinic in Chicago. These are good, clean, modern clinics, with people dedicated to health care and dentistry who are helping these people.

We envision 10,000 more community health clinics as a result of this bill, at least, and thousands of primary care physicians to be there to help. That will mean we will be creating, across America, a network of care and peace of mind for people who otherwise have few places, if any, to turn.

I think the day will come soon when this bill, after it is passed, will become evident to America in terms of what we set out to do and what we achieved. If history serves, as it has in the past, many of today's critics will not dwell on the fact that they voted no, but rather say I had some problems with it. I guess it worked out OK. They may be afraid to acknowledge that now. I think ultimately they will have to.

This is clearly an idea whose time has come, and it has come because we have a President with the courage, the political courage, to step up and make sure that we not back away. As Franklin Roosevelt did in Social Security, as Lyndon Johnson did with Medicare, Barack Obama, with health care reform, has challenged this Congress not to ignore a problem that has haunted the Presidencies of seven great men who have previously served in that office.

We need to do our historic duty in the early morning hours so that Americans across this Nation can wake up to the stories on the news that, finally, hope is on the way.

I said the other night when I was talking about this—Senator DODD put Vicki Kennedy's Washington Post column in the RECORD, and I am glad he did so—that this has been called many things. It has an official name. I am going to call it ''Kennedy Care.'' I hope some others will too, because we do it because of the inspiration of a great friend, a great Senator, and a great statesman, Edward Kennedy, who I am sorry cannot be here to enjoy this historic moment. But he led us to this moment. As he said in one of his last columns he wrote about health care: We are almost there. In four hours, we will be there.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, first, I commend Senator DURBIN for his great leadership—he is our assistant majority leader—and for all of his handiwork on this bill. He has been one of our strongest proponents for making coverage more affordable for small businesses. He just spoke about that.

In fact, under the managers' amendment, we have expanded, even more than what we did in the original bill, credits for small businesses. These credits now start in 2010. They start next year. They are available to more small business firms than we had in the original bill—all of that, thanks to the hard work and intervention by Senator DURBIN.

I might note we have a provision also in the managers' amendment relating to cardiac care, congenital heart disease. I know Senator DURBIN had a personal tragedy in his own family because of that. So we now have a new program to track the epidemiology of congenital heart disease; it is section 10411, in case anyone is taking notes. It expands on research at NIH on congenital heart disease. We are grateful to Senator DURBIN for including that.

Basically, of all the things we have for consumer protection, consumers of America have no more dogged champion here in the Congress than Senator DURBIN of Illinois. No matter what it is we are passing here, Senator DURBIN always looks to see how consumers are affected. He has done that also on this health care bill, by making sure that consumers have better protections and health care is more affordable. I personally thank Senator DURBIN for all of his hard work on this bill.

As Senator DURBIN said, and as our leader, Senator DODD, said, in about 4 hours—a little less than 4 hours now—the historic vote will take place in the Senate. It will be the defining vote of my Senate career. That has been about 25 years, I guess, I have been here. It will probably be the defining vote for all of us during our tenure here in the Senate. It will be the cloture vote on the managers' package. From that we move forward.

I hope after that cloture vote, and after we take that cloture vote, the minority side would see fit, then, since we have the 60 votes, after we have crossed that hurdle, that perhaps they would be willing to close up the debate a little bit sooner than ending on Christmas Eve. But if that is their desire—I mean, they have the rules. We will abide by the rules. If the Republicans want to exercise every single right they have under the rules, they can keep us here until Christmas Eve. There is no doubt about it. But to what end, I ask? To what end?

We are going to have the vote at 1 o'clock that is going to require the 60 votes. Then why stay here until Christmas Eve to do what they know we are going to do, and that is to have the 60 votes on the managers' amendment, on the substitute, and on the underlying bill? I hope our Republican leader and others on the other side would perhaps see that it is not in the best interest of the Chamber, it is not in the best interests of the country.

I know one of the Senators on the other side was talking about waste today. I am thinking, you know, this is kind of a waste, that we are here yakking about this and doing it up until Christmas Eve, when we could collapse all these votes and get it done tomorrow. We could actually be done here tomorrow with this whole bill if the Republicans would see fit. Like I say, it is up to them. They can keep us here if they want to. But the managers' amendment we are going to vote on at 1 o'clock—again, I keep hearing all day today from the Republicans that they have not had a chance to read it, we are rushing it, and it just came out the other day. The Republicans had it read word for word. The few times I came on the floor during the reading, I didn't see many Republicans over there listening to it. You have to wonder, did they all go home and read it? They made the clerk read it. Why didn't they sit here and listen to it? They would have found out what was in it if they were so interested.

Anyway, this is all gamesmanship around here right now. People of America understand that, too. They know we are going to pass health reform, and the first vote is going to be at 1 a.m. this morning. I heard the Senator from Arizona earlier today talking about why should we have it at 1? Why can't we have it at 9 a.m. in the morning? He said the majority leader, Senator REID, has the power. He could move it to 9 a.m. in the morning and we would not have to bring people here at 1 a.m. He referred to the Senator from West Virginia, Senator BYRD, by name—elderly, frail, but he shows up here to vote. But dragging him out of bed at 1 in the morning to come here? He said, Why don't we do it at 9 in the morning?

I thought that was a pretty good idea. When I got to the floor a couple of hours ago, I asked unanimous consent at that time that we have the vote at 9 a.m. but that the hours from 1 to 9 be counted for purposes of the 30 hours. The Republicans objected. So much for their concern for the Senator from West Virginia.

We are on the cusp. We are going to expand small business credits. We are going to reduce administrative costs. We are requiring insurance companies to spend 80 to 85 percent of their income on health care—on health care, not fancy corporate offices, not high, expensive CEO salaries of millions of dollars a year, not fancy jets, but 80 to

85 percent must be spent on health care and paying medical claims.

As Senator DURBIN said, we make major investments in community health centers—10,000 more community health centers in America. We are investing in the National Health Service Corps to get more young people to serve in the National Health Service Corps. We have new protections for patients, access to a primary care provider of their choice, and an important provision championed by the Senator from Maryland—I think Senator CARDIN—to provide access for women in their choice of an OB–GYN. In other words, they get to pick who their OB–GYN is, not their primary care provider, not the health insurance company, not anyone else. The individual woman can pick her own OB–GYN.

The amendment we have before us immediately allows children to stay on their parents' health insurance until they are age 26. The managers' amendment also prohibits insurance companies from imposing preexisting conditions on children up through the age of 18 right away, next year. Think about that. Think about what that means to a family who has a child who maybe was born with a defect—something that is chronic. The insurance companies tend to exclude them. Our bill says that beginning next year they cannot do that anymore to children. That is a big deal for so many families in this country who have kids who have been afflicted with a birth defect or maybe something happened, maybe they had an accident, maybe they had an illness early in life that has turned chronic. This is a very big deal for those families.

Last, for someone like me who represents a lot of rural areas and small towns, we have increased, in the managers' amendment, more workforce. We are going to have more people for rural and underserved communities. We will increase the funding in the training programs for rural health providers, so small towns and rural areas of the country have a big boost in the managers' amendment.

We are going to put more money and more loan repayments for people who want to serve in underserved areas, in rural areas, to make sure they do not have to go someplace where they get a lot of money to pay back their debts for medical school. We are going to be providing some of those payments if they serve in a rural area, an underserved area.

I know we have now another hour to listen to the Republicans tell us why we ought to put this off for another century or so, I suppose. The people of America know the time has come now. We are committed to this. At 1 a.m., we will have the 60 votes, and we will get this passed before Christmas. It will be one of the best Christmas presents this Congress has ever given the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, the reason I wasn't on the floor for a large part of yesterday is I was wading through this amendment and also the CBO score and also the Joint Tax score. Then I had to talk to experts who could interpret what is in there. The American people don't have that privilege. They have to rely on the stuff they are hearing on the floor. I can tell you, they are pretty upset. I get letters and calls from all over the country saying: Stop this bill any way you can. Make them get it right. I have to tell you, some of those from other States, they are saying: My Senator is not listening to me. I am counting on you.

I rise to speak on the issue of the health care reform. I rise with a great sense of disappointment as I reflect on the debate that might have been. From the very start, I have said we need to reform our health care system. Everyone agrees we need real changes that will allow every American to purchase high-quality, affordable health insurance. Not a single one of my Senate colleagues on either side of the aisle supports the status quo. The argument that Republicans support the status quo is simply false. We understand the current system fails too many Americans. We want to support reforms that will provide real insurance options to all Americans and help lower the cost of that insurance. I have said from the start of this year—and, frankly, throughout my 13 years in the Senate—that true reform should be developed on a bipartisan basis so the legislation will incorporate the best ideas from both sides and will have the broad support of the American people. That should be a prerequisite to any proposal that will affect nearly 20 percent of our Nation's economy and the health care of every single American.

Unfortunately, that was not the process followed in developing this bill. Instead, we have the Reid bill, which was developed in secret without the input of a single Republican. This morning an adviser to President Obama was asked about the partisan nature of this bill and the overwhelming opposition of the American people. His response spoke volumes of what is wrong with Washington today. He essentially responded that the American people don't understand what is in this bill and that once it is implemented, they will come to support it. In plain English, the White House is saying: Washington knows best. That attitude is part of the reason why support for Congress is at a historic low and why public support for this bill is so weak.

Instead of having a bill that will provide greater choices and reduce costs, we have a bill that will do the opposite. The Reid bill will deny consumers the ability to make choices and instead substitute the judgment of government bureaucrats who will decide what kinds of insurance you will be allowed to purchase. The bill also fails to address the most important issue for the majority of Americans. It fails to do anything to help reduce the cost of health care. President Obama promised the American people that health care reform would reduce health care costs. Yet this bill fails to deliver on the President's promise.

According to the President's own independent Medicare Actuary, this bill will actually increase how much we spend on health care. According to Rick Foster, the person from the administration who keeps track of all Medicare and Medicaid spending, the bill increases health care costs $234 billion more than if we did nothing. That is a huge cost.

In addition to increasing total costs, the Reid bill will increase our national debt and threaten the health care provided to millions of Medicare beneficiaries. Some of my Democratic colleagues are going to come down to the floor and argue that the Reid bill will reduce the deficit and extend the solvency of the Medicare Program. They have been doing that for days. They will even cite the Congressional Budget Office to support their arguments. I hope every American hears those arguments and remembers a few inconvenient truths my Democratic colleagues are going to forget to mention. The way my colleagues on the other side of the aisle were able to force CBO to conclude that the Reid bill will not increase the deficit was by requiring them to use budget gimmicks and assumptions that would make Bernie Madoff blush.

Every time you hear one of my Democratic colleagues argue that the bill reduces the deficit, you should ask that Senator if he believes that Medicare will cut physician payments by 21 percent in March. That is right. While the Reid bill cuts over $470 billion from the Medicare Program, it will also require that every doctor treating Medicare patients have his or her payments cut by 21 percent in just 2 months. That is what CBO had to assume when they did their estimate. If you believe Congress will never allow this to happen—and we never have—you cannot believe this bill will actually reduce the deficit. The truth is Congress has never allowed that level of cut. Senate Democrats, however, chose to ignore this reality and relied on the promise of a cut to make their bill add up. You should also ask my Democratic colleagues if they believe that Medicare payments to doctors will be cut more than 45 percent over the next decade.

Again, that is what the Reid bill required CBO to assume. If you don't think that will happen, then you cannot believe this bill reduces the deficit.

You should also ask my Democratic colleagues if they think that within a decade one out of every five hospitals, nursing homes, and home health agencies will be operating at a loss because of the unsustainable payment cuts in this bill. We just got a revised CBO estimate that says there was a little error there, and so there will be less savings by $600 billion. According to

the administration's Actuary, Rick Foster, that is exactly what is going to happen if the Reid bill is enacted. He said if these policies have to be modified, such changes would likely result in smaller actual savings. This means this bill will not reduce the deficit.

Finally, you should ask anyone arguing that this bill reduces the deficit whether they believe Medicare patients will not be able to get the care they need. Again, the administration's own Actuary says payment cuts in the Reid bill could jeopardize access to care for beneficiaries. I do not know if my colleagues believe these things will happen. Taking note of these facts pushes up the total cost of the bill well over $1 trillion and destroys any pretense of budget balance. Unless all the things CBO was required to assume actually happen, this bill will actually increase the deficit.

Health care reform has to be truly paid for. Why? Because the Federal Government has maxed out its credit cards. Our out-of-control spending is now even driving down the value of our money. As the government borrows more money to finance even more spending, the devalued dollar will drive up the cost of goods. Oil is a good example. Take a country such as Saudi Arabia, which is already raising prices for their oil to compensate for the lower value of our dollars. This means every American will end up paying more for a gallon of gas because of our failure to address growing deficits. If we are going to enact real health reform, we need to use honest accounting and not budget gimmicks and fake assumptions that we all know will not happen.

We should pay for expenses such as fixing doctors' Medicare payments, and we should not delay the start of spending 4 years after the start of the new taxes just to make the bill look good over 10 years.

The problem for the President and my Democratic colleagues is their bill is being sold on the strength of accounting tricks that make it appear that it will not add to the deficit. In case they have not noticed, they are not fooling the American people. It showed up in August. It showed up every time since then. That is why we are not getting to go home on weekends. We don't want the Democrats to hear from the people at home who are upset about this.

In a recent poll, 68 percent of Americans said they believe the Democrats' health reform bill will increase the deficit. They are right. The American people understand that if the Reid bill is enacted, deficits will increase. They are right. The same is true for the claims that the Reid bill will extend the solvency of the Medicare Program or reduce beneficiary premiums. That can only happen if you make all the assumptions I previously described. If you don't believe those things will actually happen, then this bill will do nothing to extend Medicare or lower premiums.

Besides driving up the deficit, the Reid bill will also eliminate more than 1 million jobs. The mandate that employers offer health insurance or pay a penalty will be a massive new job-killing tax. Our national unemployment rate is at 10 percent. The majority leader is attempting to cut off debate on a bill and force its passage before Christmas, again, because he doesn't want the people to hear what is happening, but we are going to see that that does happen—that will force employers to eliminate jobs and reduce wages. Businesses do not deny health care to their employees because they are cruel or mean-spirited. They do it because they can't afford it.

Most businesses that do not provide coverage do so because they cannot afford health insurance. They can't afford it for their employees or for their own families. They have looked at the cost and figured out they cannot pay for health care and still stay in business. The Reid bill fails to do anything to actually lower the cost of health insurance, which might mean these businesses could actually afford health insurance. Instead, it will place a new tax on these businesses, which the CBO has said will lead to these businesses reducing wages for their workers and eliminating jobs. That is why the National Federation of Independent Business, which represents small business across America, estimated the Reid bill would cause 1.6 million jobs to be eliminated. That is why they said the Reid bill will create a reality that is worse than the status quo for small business.

The worst thing about the Reid bill is not how it will increase the deficit or kill 1 million American jobs. The worst thing about the Reid bill is it will reduce the quality of health care we all receive. No longer will you and your employer be able to choose the health insurance that best meets your needs. The government will tell you what kind of insurance you have to buy, and if you don't, you are told the government will place a fine on you. Under the Reid bill, the government will tell your health plan which types of doctors they have to contract with, irrespective of whether that is a doctor you want or need to see. The Reid bill also traps 15 million Americans in the worst health care program in America. Approximately half the people who get the promised health care coverage under the Reid bill will get it through the broken Medicaid Program.

States already use price fixing to limit how much they have to pay doctors under the Medicaid Program. That is why as many as 40 percent of all doctors will not see Medicaid patients. I have said, if you can't see a doctor, you don't have health care. Yet that is exactly what the Reid bill will do: Promise 15 million people coverage but trap them in a system where we know they will not be able to get the care they need.

If anyone doubts what effect the Reid bill will have, they only need to look at Massachusetts. The Massachusetts plan was the model for many of the reforms in this bill. The problems they are encountering give us a good indication of what will happen to us all if the Reid bill is enacted.

To make the Massachusetts reforms work, they now have a 10-member commission trying to impose a global payment system. Under this system, doctors and hospitals will be forced to join large networks and be paid at a set rate for each patient. This is the same kind of government control we already see with Medicaid. The results of these changes are equally predictable. Fewer doctors will be willing to see people at the exact time when the number of people seeking care is increasing.

These are just some of the more serious problems with this bill. Because many of my colleagues want to be able to discuss the problems with this bill, I have limited my remarks for now. Because the bill was drafted behind closed doors and thrust upon the American people without time to consider all the ramifications, I am sure we will find more problems with the legislation after this rushed vote.

Over the next few days, I plan to lay out specific and concrete alternatives to how we could do better. I have been doing that for a long time, but they have not been accepted. Republicans have many ideas on how to make this bill better, including several that have bipartisan support. However, if Senator REID is successful in cutting off debate, we will never get the chance to discuss any of these ideas.

Health care reform is too important for too many Americans to be rammed through the Senate with little or no debate on the weekend before Christmas. It appears my colleagues understand how deeply unpopular this bill is with the American people, and they want to force it through when they believe most Americans are not paying attention. I wish to assure my Democratic colleagues that the American people are watching, and the voices of August will only grow louder. They will remember the vote to cut off debate on this bill for a long time because they understand what it will mean for their health care and the future of this country. The person with whom I served in the Wyoming Legislature sent me a little note and said: If it is broken, don't break it more. That is what we are doing.

I have some articles I wish to include in the RECORD. One is by Howard Dean that suggests this reform falls short. Of course, he is the former chairman of the Democratic National Committee. Another is an editorial by Matthew Dowd, a political analyst for ABC News, who talks about the danger of success and where the polls are on this and says:

> If this legislation passes, Democrats will be held accountable for any failures or problems in the system. So if any Americans' insurance premiums rise, they will blame the Democrats. If patients have to wait in line at

emergency rooms, it will be seen as the Democrats' fault. If health care costs don't drop, the Democrats will face the wrath of the electorate.

I also have an editorial by E.J. Dionne, Jr., about Democratic fratricide and an article by George Will, where he says ''More talk, less support.'' The more we talk, the less support there is for this bill.

Finally, I have an editorial by David Broder, of December 18, 2009.

I ask unanimous consent to have these articles printed in the RECORD.

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

[From the Washington Post, Dec. 17, 2009]

REFORM THAT FALLS SHORT

(By Howard Dean)

If I were a senator, I would not vote for the current health-care bill. Any measure that expands private insurers' monopoly over health care and transfers millions of taxpayer dollars to private corporations is not real health-care reform. Real reform would insert competition into insurance markets, force insurers to cut unnecessary administrative expenses and spend health-care dollars caring for people. Real reform would significantly lower costs, improve the delivery of health care and give all Americans a meaningful choice of coverage. The current Senate bill accomplishes none of these.

Real health-care reform is supposed to eliminate discrimination based on preexisting conditions. But the legislation allows insurance companies to charge older Americans up to three times as much as younger Americans, pricing them out of coverage. The bill was supposed to give Americans choices about what kind of system they wanted to enroll in. Instead, it fines Americans if they do not sign up with an insurance company, which may take up to 30 percent of your premium dollars an spend it on CEO salaries—in the range of $20 million a year—and on return on equity for the company's shareholders. Few Americans will see any benefit until 2014, by which time premiums are likely to have doubled. In short, the winners in this bill are insurance companies; the American taxpayer is about to be fleeced with a bailout in a situation that dwarfs even what happened at AIG.

From the very beginning of this debate, progressives have argued that a public option or a Medicare buy-in would restore competition and hold the private health insurance industry accountable. Progressives understood that a public plan would give Americans real choices about what kind of system they wanted to be in and how they wanted to spend their money. Yet Washington has decided, once again, that the American people cannot be trusted to choose for themselves. Your money goes to insurers, whether or not you want it to.

To be clear, I'm not giving up on health-care reform. The legislation does have some good points, such as expanding Medicaid and permanently increasing the federal government's contribution to it. It invests critical dollars in public health, wellness and prevention programs; extends the life of the Medicare trust fund; and allows young Americans to stay on their parents' health-care plans until they turn 27. Small businesses struggling with rising healthcare costs will receive a tax credit, and primary-care physicians will see increases in their Medicare and Medicaid reimbursement rates.

Improvements can still be made in the Senate, and I hope that Senate Democrats will work on this bill as it moves to conference. If lawmakers are interested in ensuring that government affordability credits are spent on health-care benefits rather than insurers' salaries, they need to require state-based exchanges, which act as prudent purchasers and select only the most efficient insurers. Sen. John Kerry (D-Mass.) offered this amendment during the Finance Committee markup, and Democrats should include it in the final legislation. A stripped-down version of the current bill that included these provisions would be worth passing.

In Washington, when major bills ear final passage, an inside-the-Beltway mentality takes hold. Any bill becomes a victory. Clear thinking is thrown out the window for political calculus. In the heat of battle, decisions are being made that set an irreversible course for how future health reform is done. The result is legislation that has been crafted to votes, not to reform health care.

I have worked for health-care reform all my political life. In my home state of Vermont, we have accomplished universal health care for children younger than 18 and real insurance reform—which not only bans discrimination against preexisting conditions but also prevents insurers from charging outrageous sums for policies as away of keeping out high-risk people. I know health reform when I see it, and there isn't much left in the Senate bill. I reluctantly conclude that, as it stands, this bill would do more harm than good to the future of America.

THE DANGER OF SUCCESS

(By Matthew Dowd)

President Obama needs an exit strategy. I am not referring to Afghanistan or Iraq (though there are quite a few similarities between the situation Obama is in on health-care reform and the political difficulties President George W. Bush faced on Iraq). Congressional Democrats and Obama are headed toward a ''catastrophic success'' politically if they pass health-care reform in its current legislative form. And catastrophic success was a term then-President Bush used on Iraq when he acknowledged the great initial victory but didn't take into account the long-term calamity and costs.

I am not seeking to argue the substance of health care and the merits or demerits of the bills, and will leave that to experts in policy and its effects. I am talking about the politics of the legislation and the effect it is likely to have on Obama and Democrats in Congress.

Unlike many other pundits and political experts in both parties, I think that passage of a bill by the Democrats at this point will be politically damaging to both the president and congressional Democrats. Conversely defeat of the legislation is much more likely to hurt Republicans in Congress.

The latest Post-ABC News poll shows the president's overall approval rating at a new low of 50 percent—about the rating President Bush had going into the November 2004 election, when Democrats said Bush was ripe for defeat.

There are many reasons for this drop in support for Obama. The stagnant economy is the biggest factor, but close behind is the fact that the administration is pushing health-reform efforts that have polarized the electorate, and that independent and swing voters have moved against in large measure.

As Wednesday's Post-ABC poll shows, a majority of Americans believe that if this bill passes, their healthcare costs will rise, the federal deficit will increase, the costs of the overall health-care system will climb, and their own care would be better if the system stays as is. Democrats (including former president Bill Clinton) claim that they need this bill to pass for political reasons. But let's examine that. At present, a majority of Americans are against the effort, the legislation lacks bipartisan support, the costs of the reforms are upfront, and the benefits won't kick in until after the 2012 elections. When has that ever been a formula for political success?

If this legislation passes, Democrats will be held accountable for any failures or problems in the system. So if Americans' insurance premiums rise, they will blame the Democrats. If patients have to wait in line at emergency rooms, it will be seen as the Democrats' fault. If health-care costs don't drop, the Democrats will face the wrath of the electorate.

Many Democrats, including people in the administration, blame poor marketing for their difficulties in passing health reform. They say they haven't gotten the message out. But advocates of reform have spent millions on advertising and lobbying this year. And Obama, who many say is the best orator ever to occupy the White House, has pushed for this legislation constantly over the past six months. In that time, support for Obama's handling of heath-care reform has dropped by more than a net of 30 points.

Yet before Republicans cheer that they may defeat this effort, they should beware what they wish for. A vast majority of Americans still believes that we need fundamental health-care reform. If the legislation fails, Democrats can blame Republicans by saying reform was in sight and the GOP blocked it without offering a real alternative to decrease costs and increase access.

The dominant issues today are the economy and jobs, and the public doesn't see either party making these a real priority. Further, polls show trust in government handling of domestic issues remains at historic lows. What most voters hear from Washington these days is squabbling over health reform involving a government role they don't trust and don't want.

My advice? Leaders in Washington ought to concentrate on what matters to Americans, not on what they think should matter to voters. Come up with a heath-care bill that draws real bipartisan support. And before pushing a bigger role for government, begin to restore trust in the government's ability to do even small things. Democrats pushing so hard for success on health care could find themselves in a situation resembling President Bush's situation on Iraq. They could topple the statue and win the day, but lose politically over the coming months and years.

DEMOCRATIC FRATRICIDE

(By E.J. Dionne, Jr.)

Here's what Democrats need to ponder: Can they prosper in the absence of George W. Bush?

His presidency was a tonic for Democrats and led to a blossoming of political creativity on the center-left not seen since the 1930s. No tactic, no program, no leader ever did more to catalyze the party than the rage Bush inspired.

The whole effort was summarized nicely by the party's slogan in 2006, ''A New Direction for America.'' There was no need to specify north or south, east or west, up or down. Compared with Bush, any alternative destination seemed appealing. And by becoming the apotheosis of the fresh and the new, Barack Obama emerged as the most attractive guide to this unknown promised land.

The consequence is that Democrats must govern in one of the most difficult periods in American history while managing a sprawling coalition and working though a political structure near the point of breakdown—

largely because of the dilapidated state of that dysfunctional and undemocratic partisan hothouse, the United States Senate.

Especially if you take into account the scope of the problems confronted, Democrats could argue they are doing pretty well. It's no small thing to save the economy from collapse. Winding down two wars is no picnic.

But politically, the Democrats are in trouble. They are at one another's throats over healthcare legislation that should be seen as one of the party's greatest triumphs. They are being held hostage by political narcissists and narrow slivers of their coalition.

When Democrats make deals, they are accused of selling out. When they fail to make deals, they are accused of not reaching out. Moderates complain that their party has gone too far left. Progressives chortle bitterly at this, asking: What's left-wing about policies that shore up banks and protect drug companies?

Rural-state centrists insist on more fiscal discipline—as long as it doesn't affect farmers and small-town hospitals. Progressives ask why debt should be the priority when so much more needs to be done to relieve unemployment.

This is a recipe for political catastrophe. An increasingly bitter and negative Republican Party may not be able to win the midterm elections, but Democrats definitely can lose them.

Their fractiousness is dispiriting to their supporters, which set off this urgent warning bell in the latest Post-ABC News poll: For the first time in his presidency, more Americans strongly disapprove of Obama's performance in office (33 percent) than strongly approve (31 percent).

Putting aside margins of error and the fact that the Dec. 10–13 poll showed a sudden bump in Republican identification, that might be a statistical anomaly. The point is that the trend is perilous. In June, strong approvers of Obama outnumbered strong disapprovers 36 percent to 22 percent. Ardor and energy are switching sides.

There are no instant cures, but there is one thing that must be done fast: Democrats need to agree on a health bill and sell it with enthusiasm and conviction. Their own turmoil and back-stabbing are making what is a rather good plan look like a failure while convincing political independents that they are a feuding gang rather than a governing party.

They have to focus in 2010 on immediate job creation and long-term economic mobility while explaining how aggressive measures to boost the economy now go hand in hand with eventual deficit reduction.

Congressional moderates must understand that their fate is linked with the party's ability to govern, and grass-roots progressives have to be less on a hair trigger to shout betrayal. (I wish I knew what to do about Joe Lieberman.)

For his part, Obama has not appreciated until recently how closely he has been tied to Wall Street and the banks. He has been too reluctant to underscore how much of Washington's dysfunction has been pushed to new levels by the Republican Party's decision to grind the Senate to a halt. He has tried to make clear the size of the mess he inherited from Bush, but has not sold the country on the extent to which he has begun to clean it up.

Americans may not be sold on anything until unemployment starts dropping. Even then, Democrats will have a tough time making the sale if the process that produced the health-care bill comes to define the image of how they govern the country. Democrats have every right to blame Bush for the fix we're in. They can't blame him for the problems they're creating for themselves.

MORE TALK, LESS SUPPORT

(By George F. Will)

Rushing to lock the nation into expensive health-care and climate-change commitments, Democrats are in an understandable frenzy because public enthusiasm for both crusades has been inversely proportional to the time the public has had to think about them. And the president pushing this agenda has, with his incontinent hunger for attention, seen his job approval vary inversely with his ubiquity. Consider his busy December—so far.

His Dec. 1 Afghanistan speech to the nation was followed on Dec. 3 by his televised ''jobs summit.'' His Dec. 8 televised economics speech at the Brookings Institution was followed on Dec. 10 by his televised Nobel Peace Prize acceptance speech, which was remarkable for 38 uses of the pronoun ''I''

And for disavowing a competence no one suspected him of. (''I do not bring with me today a definitive solution to the problems of war.'' Note the superfluous adjective) And for an unnecessary notification. (''Evil does exist in the world.'') And for delayed utopianism. (''We will not eradicate violent conflict in our lifetimes.'' But in someone's.) And for solemnly announcing something undisputed. (There can be a just war.) And for intellectual applesauce that should get speechwriters fired and editors hired. (''We do not have to think that human nature is perfect for us to still believe that the human condition can be perfected.'' If the human ''condition'' can attain perfection anyway, human nature cannot be significantly imperfect.)

Then on Dec. 13, he was on ''60 Minutes'' praising himself with another denigration of his predecessor, a.k.a. ''the last eight years.'' (Blighted by ''a triumphant sense about war.'') When Attorney General Eric Holder announced last month that five suspected terrorists would be tried in federal courts, he said: ''After eight years of delay. . . .'' When the US. Preventive Services Task Force made the controversial recommendation that women should get fewer mammograms, Secretary of Health and Human Services Kathleen Sebelius said: This panel was appointed by the prior administration, by former President George Bush.'' In congressional testimony, Treasury Secretary Timothy Geithner almost deviated from the script. He said the Obama administration began after ''almost a decade''—slight pause—''certainly eight years of basic neglect.''

Abroad, the fruits of the president's policy of ''engagement'' have been meager: Witness Iran continuing its nuclear program and China being difficult about carbon emissions. Here is a history lesson for an administration that, considering itself the culmination of history, is interested only in the past eight years of it:

At a Vienna summit in June 1961, President John Kennedy, fresh from his Bay of Pigs fiasco, was unnerved by the brutal disdain of Soviet Premier Nikita Khrushchev, who considered Kennedy callow. Britain's Prime Minister Harold Macmillan astutely noted that Kennedy had ''met a man who was impervious to his charm.''

A person can be a novelty only once, and only briefly, and charm, like any commodity, when used uneconomically, becomes a wasting asset. All this is pertinent to the Senate health-care debate, now coming to a curious climax amid another glut of careless grandiosity.

Supporters of the Senate bill say it will insure the uninsured. The Congressional Budget Office says 24 million of the 46.3 million uninsured will remain so. Supporters say it will lower aggregate and individual health-care spending. The government's Centers for Medicare and Medicaid Services says the nation's health-care spending and insurance premium costs will increase.

Today there are more independents than Democrats, more independents than Republicans, and according to a recent Gallup poll, independents approval of the Democratic-controlled Congress (14 percent) is lower than Republicans' approval (17 percent). This is partly a function of the majority party's health-care monomania. Consider what happened recently in Kentucky.

There a Republican candidate succeeded in nationalizing a state Senate race. Hugely outspent in a district in which Democrats have a lopsided registration advantage, the Republican, by 12 points, won a seat in Frankfort by running against Washington—against Nancy Pelosi, Harry Reid and their health-care legislation.

A CNN poll shows 36 percent of the public in favor of what the Democratic Senate is trying to do to health care, 61 percent opposed. It is clear what the public wants Congress to do: Take a mulligan and start over.

So Republicans can win in 2009 by stopping the bill or in 2010 by saying: Unpopular health-care legislation passed because of a 60–40 party-line decision to bring it to a Senate vote. Therefore each incumbent Democrat is responsible for everything in the law.

DISHING OUT SOME SHOCK ON DEBT

(By David Broder)

The 34 names are familiar to anyone who has followed economic policy in Washington for the past generation, one-third of them former chairmen or members of key committees of Congress, seven of them former comptroller generals of the United States, seven of them former directors of the Congressional Budget Office and one of them—Paul Volcker—the former chairman of the Federal Reserve System and now an adviser to President Barack Obama.

Both political parties are well represented in their number. But they came together this week as signatories of a nonpartisan manifesto, essentially a stark warning to the president and Congress and a plea for action on behalf of the next generation.

The United States, they unanimously said, is facing ''a debt-driven crisis—something previously viewed as almost unfathomable in the world's largest economy.''

Under the impact of the worst economic calamity since the Great Depression, the federal government ran a deficit of $1.4 trillion this past year. The rescue effort was necessary, but in 2009 alone, the public debt grew 31 percent from $5.8 trillion to $7.6 trillion, rising from 41 percent to 53 percent of gross domestic product (GDP).

Unless strong remedial steps are taken, the debt is projected to rise to 85 percent of GDP by 2018 and 100 percent four years later. Barely a dozen years from now. these deeply experienced folks say, the American economy will likely be in ruins.

All of us have become accustomed to hearing lamentations about the changes in the annual budget deficits, the gap between federal revenues and spending in a particular year. But this commission deliberately shifted its focus from the deficit to the underlying debt.

The reason was explained to me by Alice Rivlin, formerly a director of both the Congressional Budget Office and the Office of Management and Budget. ''Previously, when we were worried about deficits, we could take comfort in the fact that the debt was not very high relative to the economy,'' she said. ''But now that debt has shot up. The cushion has gone. If the same thing (a severe recession) happened again, we wouldn't be able to borrow to deal with it.''

In addition to robbing us of the flexibility to deal with future crises, the rapidly rising debt level could push up interest rates, threatening economic recovery, slow the growth of wages, depress living standards, make the United States even more dependent on foreign lenders and leave us vulnerable to a shock wave if those lenders lose confidence in our ability to repay the loans.

These experts—writing under the auspices of the Peter G. Peterson Foundation, The Pew Charitable Trusts and The Committee for a Responsible Federal Budget—suggest a series of steps.

First, they want Obama in his State of the Union address to urge Congress to join in a pledge to stabilize the debt, at no higher than 60 percent of GDP, by 2018. This would require actions by both Congress and the administration to start reducing the projected annual deficits, which add to the debt, That would make debt-management an economic priority once the effects of the current severe recession have eased. To assure the pledge is kept, those who signed this report would ask Congress and the president to set up an enforcement mechanism that would automatically reduce spending or increase taxes when the debt target is missed in any year between 2012 and 2018.

This is stiff medicine, but the message of this report is that temporizing on this issue poses such perils to the nation's future that the risk is unacceptable.

When Congress this week ducked its responsibility again by deciding to enact a temporary, two-month increase in the debt ceiling, the need for a shock treatment like this report could not be plainer.

Mr. ENZI. I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I thank the Senator from Wyoming for his important leadership. He is absolutely right. As much as we would all like to be home with our families, especially at this time of year, this battle to inform the American people about what is about to happen to them is too important for us to simply give up or acquiesce to what the Senator from Iowa seems to think is inevitable.

There is nothing inevitable about this. The only thing I think inevitable about it is, in light of the unpopularity of what is being jammed down the throats of the American people, there will be a day of accounting. We do not know when that day of accounting will be. Perhaps one of the first days of accounting will be election day 2010. I do not understand how people who are elected to represent their constituents can try to impose something that is so obviously unpopular with their constituents and expect somehow to be patted on the back and told: Well, you are right, you are smarter than we are. You do know better than we do what is better for our families and what we ought to be limited to when it comes to health care choices.

I think that is an upside down way of looking at the world. Maybe that is the reason why we have such disparate views of what we are engaged in here. Clearly, on the other side of the aisle, they believe that government is the answer. They believe government can do a lot better than the private sector in providing choices and providing cost controls. Well, the only way government can do that, of course, is by price controls, which we have seen happen in Medicare and Medicaid, which have not worked very well. Here we are 5 days before Christmas, and we are going to be having a vote tonight at 1 a.m. on a 2,733-page health care bill that we got yesterday morning. We do not know what is in the bill. We are still reading, and apparently the Congressional Budget Office is still trying to figure out the impact of the bill. They have already had to correct one mistake because they are being asked to rush to judgment on this bill that will affect one-sixth of our economy and all 300 million Americans.

But we do know this: We do know it will cut Medicare by $470 billion. Medicare is paid for by employers and the workers into a trust fund, and that trust fund is going to be pilfered, robbed, in order to create a brandnew entitlement program that the beneficiaries of that entitlement program never paid for as did the beneficiaries of Medicare. That is one part of this. We also know it is going to increase taxes by $518 billion.

We already know President Obama's promise as to people making less than $250,000 a year will not be kept under this bill, and that this bill, according to the National Federation of Independent Business, will impact small businesses and their ability to create jobs and retain workers during one of the worst recessions we have had in this country.

Then, of course, we know this bill—without the phony accounting gimmicks, such as implementing a bill 4 years into a 10-year budget window—will actually fail in universal coverage. It will leave 23 million people uninsured, and it will cost roughly $2.5 trillion, and it will increase the cost of premiums for people who already have insurance.

What is so disgusting about this process is, this exactly confirms the most cynical view that the American people have about Congress and Washington, DC. Rather than a change in that process—one that is more transparent, one in which everybody's views are considered, and where we try to come together in a bipartisan consensus for a solution—this is going to be passed strictly along party lines by a political party and by their leadership who apparently care more about chalking up a victory, albeit a Pyrrhic victory, rather than listening to their constituents. The American people want Washington to start over again. Fifty-six percent of voters in this most recent poll said they want us to stop this bill and start over.

We know this process is a product of deals struck behind closed doors with special interest groups and their lobbyists. The pharmaceutical industry got 24 Democrats to switch their votes on reimportation. What is that all about? To preserve a special deal cut behind closed doors? The insurance industry will get $476 billion of tax money from this bill. Then other parts of the health care community are going to be exempted from cuts by the payment advisory board because they cut their deal behind closed doors. We know this bill is being attempted to be jammed through when most people are spending time with their families because of the Christmas season.

Even the distinguished majority whip, last week, said: I am in the dark almost as much as other Senators are. He said: I am in leadership. So this bill has been written with a small group of people behind closed doors, including the Senator from Nebraska, who spent 13 hours—13 hours—on Friday behind closed doors with Democratic leadership and White House officials. In the meantime, we are left completely in the dark as to what is in this bill other than what we could glean in the limited time we have been given.

After the ill-fated stimulus bill passed in the first part of the year, I remember we got that bill about late Thursday night, and then we were asked to vote on it less than 24 hours later—less than 24 hours later. We—like that—spent $1.1 trillion, including the interest, in this stimulus bill that was supposed to keep unemployment below 8 percent. Well, we know how well that worked with unemployment going as high as 10.2 percent and now at 10 percent. One thing the American people told us after that is, they want us—well, I almost hate to say it, it seems so simple and straightforward—they want us to read the bill. They want us to understand the bill. They want to be able to read it and understand it before they give their consent to our voting for it. They want to know what the impact is going to be on their coverage. Is it going to raise their taxes? Is it going to raise their premiums? Is it going to cut into their Medicare benefits? If you are a Medicare Advantage beneficiary, we know it will for 11 million Americans, including half a million in Texas.

Then there was this discussion, and I guess this is all for show too. This was not, obviously, a sincere effort where we had eight Democrats who wrote a letter on October 6 to the majority leader and said they want the bill 72 hours before the first vote. Well, guess what. This historic vote we are going to have at 1 in the morning will occur 40 hours, roughly, after we got the bill. So much for 72 hours. We know the CBO, the Congressional Budget Office, score, the cost, their estimate, even with the phony assumptions that are included in this bill, will only be available for 37 hours.

Then we find out there are other sweetheart deals which makes this begin to stink to high heaven—things such as special legislative language saying the State of Nebraska—the State of Nebraska—gets a special pass from new Medicaid mandates. Vermont and Massachusetts have special deals. Then there is a $100 million earmark

for an unknown hospital. Boy, I cannot wait to find out what that is about. Those are just some of the sweetheart deals we know are in these bills, and I am sure there are more we will find out about.

This process has gone too fast and gone too far off track. It reminds me of what Rahm Emanuel, the President's Chief of Staff, said when they jammed through the stimulus bill earlier this year. He said: A crisis is a terrible thing to waste.

It is one thing if we were acting in response to a crisis in a responsible manner, but what this is going to do is make it even worse, as the Senator from Wyoming pointed out.

I think people listening—the 56 percent and growing number of Americans who are concerned about this deal—are wondering: Are the politicians in Washington more interested in jamming this through or getting it right?

Senator OLYMPIA SNOWE from Maine, a member of the Finance Committee—the one Republican to vote for the Finance Committee bill—said she will not vote for cloture on this bill at 1 this morning because this is simply an arbitrary deadline. Oh—and guess what—most of the provisions do not kick in for 4 years. So why are we doing this literally in the dead of night on a phony timetable?

We know according to experts, such as the dean of the Harvard Medical School—he said:

> In discussions with dozens of health-care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it.

You do not have to go to Harvard to figure that out. Just go to Houston, TX. A small business owner in Houston wrote to me and said:

> The proposed Health Care bill is going to have a negative impact on my business because the cost of employee health insurance will go up.
>
> . . . I don't believe what some are saying that costs will go down. . . . This bill does not make economic common sense.

Those are true words from a small business owner in Houston, TX, who I suspect has a greater understanding of what this bill will be than some of the so-called experts here inside the Beltway.

We know from the Congressional Budget Office, though, that the premiums for an average American family under this bill will go up $2,100 a year for those purchasing insurance on their own in the so-called individual market.

An independent study talked about premiums in Texas specifically and said premiums in Texas, for those who purchase insurance on their own, will go up for 61 percent—61 percent—of Texans purchasing insurance on their own, that their premiums will go up under this bill. What in the world are we doing? Under the Reid bill, a family of four in Houston would see their premiums more than double to $1,352 a month.

I find it supremely ironic that perhaps the next vote we will have here on the Senate floor, after this health care bill, is going to be a vote to increase the statutory debt limit because Congress has maxed out its credit card. Currently our credit limit is $12 trillion, and now that is not enough because of unwise and reckless spending such as that reflected here in this bill. I find that supremely ironic. But I suspect there are a lot of Americans who find it very sad and even scary.

We know in a time when people are struggling to keep their job, when businesses are struggling to keep their employees rather than have to lay them off and make the unemployment statistics even worse, when people are losing their home because they no longer have a job, this bill will be a job killer.

The only way this is going to be paid for—the pay-or-play mandates put on businesses—is for businesses to take some of the money they would have used to hire new employees and pay this new punitive tax being imposed by the Federal Government.

Businesses in Texas know this is true. The Lubbock Chamber of Commerce said:

> An employer mandate would be a ''job killer'', raising the costs of maintaining a workforce. . . .
>
> . . . small businesses and our consumers will be the ones who suffer. . . .

Then there is this Medicaid expansion that Senator ENZI from Wyoming talked about. There is an unfunded mandate here because Texas did not get the sweetheart deal that Louisiana or Nebraska or Vermont or Massachusetts got—an unfunded mandate of $21 billion over 10 years. So not only are people's Federal taxes going to go up, they are going to wreck the State budget too by pushing aside other priorities such as public education and the like—totally irresponsible.

Then there is a so-called Nelson amendment on abortion that was supposed to strike a ''compromise.'' Well, one of my other constituents, Cardinal Daniel DiNardo, who leads Texas' largest archdiocese and is chairman of the U.S. Conference of Catholic Bishops' Committee on Pro-Life Activities, said this:

> [T]he legislation will be morally unacceptable ''unless and until'' it complies with longstanding current laws on abortion funding such as the Hyde amendment. . . .
>
> . . . .This legislation should not move forward in its current form. It should be opposed unless and until such serious concerns have been addressed.

I am staggered at what we are about to witness here, at the sheer irresponsibility of the way this is being done, with artificial deadlines, votes in the dead of night, bills cooked up behind closed doors as special deals jammed down the throats of the American people who do not want it.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. THUNE. Mr. President, I appreciate the comments of my colleague from Texas, and my colleague from Wyoming prior to that. Many have come down here, as our colleagues on our side have, day after day, time after time, and continue to point out what we believe is wrong with the approach that is being taken by the majority, and also pointing out where we would do things differently.

Remember, this is the first bill: 2,100 pages long; $1.2 billion per page; $6.8 million actually per word. Then yesterday, we got the managers' amendment: another 400 pages. You add yet another amendment that is going to go on this stack, and you are talking about 2,700 pages of bill language.

What I think is interesting—and I see a pattern emerging here almost every single day—it is like deja vu all over again. The other side comes down here and talks about the need for health care reform, which we all concede. We all believe we need to reform health care in this country. We all hear from our small businesses. We all hear from individuals and families who are having a difficult time keeping up with the high cost of health care. So that is something on which there is broad agreement on both sides. Yet that seems to be sort of the MO for the other side, to come down here and talk about how we need to do health care reform. We agree with that.

The other strategy is to come down here and attack Republicans for not having their own ideas. We have been trying to offer amendments to this bill forever. We had several amendments offered today. We asked consent to bring up amendments, to get them pending, to get them voted on. They were blocked by the other side. We have full alternatives to the current bill. Senator BURR and Senator COBURN have an alternative, a comprehensive alternative they would like to offer, being blocked by the other side.

So the recurring pattern that has emerged day after day in the debate in the Senate is Democrats come down here and talk about how bad the current system is and point out examples of those who are falling through the cracks in the current system. Exactly. We agree with that. We have acknowledged there is a problem. They come down here and attack Republicans for not having alternatives. In fact, the Senator from Rhode Island this afternoon essentially said that Republicans have been coming down here and telling lies.

What the Republicans have been doing day after day after day is coming down and talking about the bill and the impact the bill would have on health care delivery, the impact the bill would have on the economy, the impact the bill would have on small businesses and their ability to create jobs. We have been talking about the Congressional Budget Office report that describes the cost of the bill and goes into great detail about how it will impact individual families as well as the overall cost of health care in this

country. We have come down here day after day to talk about the CMS Actuary's report, the Center for Medicare Services, about the cost of the bill and how it would impact the cost of health care in this country. So we continue to come down here and talk about the bill.

The other side—the one thing they don't do is they don't come down here and talk about the bill. I don't hear Democrats coming down here and offering full-throated defenses for this bill, because the bill is indefensible. It is 2,700 pages, and it doesn't do anything to lower the cost of health care, according to the Congressional Budget Office.

So we come down here day after day and talk about the Congressional Budget Office report, come down here and talk about the CMS Actuary's report. They come down and talk about how bad the current system is, say this is going to fix it, but then when they are challenged on the CMS Actuary's report and the Congressional Budget Office report, they can't defend that.

What they should be doing instead of accusing the Republicans of telling lies and attacking Republicans is accusing the CMS Actuary and the Congressional Budget Office. They ought to be coming down and attacking them because all we are doing is pointing out the facts as they pertain to the current bill that is before the Senate, this 2,700 pages right here.

What I would like to point out are some of the promises that have been made by the President and by Democrats with regard to this bill.

The President made it very clear, when he was running for President:

> I can make a firm pledge: Under my plan, 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.

Yet the Joint Committee on Taxation analysis—by the way, that is another report, and maybe they ought to be coming down here and attacking that report rather than attacking Republicans who are quoting from the report. The Joint Committee on Taxation analysis shows those people earning less than $200,000 a year will see a tax increase under the Reid bill. Even after you account for taxpayers who are going to receive the premium tax credit, 24 percent of tax returns under $200,000 will, on average, see their taxes go up. There are 42 million Americans who are going to see higher taxes who make less than 200,000 a year. So the no tax increase for the middle class we would have to say is a broken promise.

The second thing they say is that it will lower health care costs. We all know—and the President said this as recently as June 23:

> And I've said very clearly: If any bill arrives from Congress that is not controlling costs, that's not a bill I can support. It's going to have to control costs. It's going to have to be paid for.

So the Democrats have shifted the benchmarks about what that means and what impact it is going to have on America's health care premiums.

The President's first promise, going back to the campaign, was that the typical family's premiums would go down by $2,500 per year—a $2,500-per-year reduction, according to the President when he was campaigning—and that everybody would be covered. Well, we all know that even this bill, which is touted as expanding coverage—well, it does expand coverage. It puts 15 million more people on Medicaid; that is one way it expands coverage. But under this bill, there are still 23 million Americans who don't get health insurance coverage. So the President's promise that he was going to cover everybody, that he was going to lower health care costs, again, you would have to say it is a broken promise.

I want to show my colleagues how this would impact a typical family's insurance costs. If you are a family who is paying $13,300 today and you are getting your insurance in the large employer market—in other words, if you work for a large employer, you get it in the large group market—and you are looking at the year 2016, you are going to be paying over $20,000 a year for insurance. That doesn't lower health care costs; that increases health care costs.

What they will say is: Well, this is better than it would have been if we had done nothing. The honest truth is that if we do nothing, we still would have 5 percent to 6 percent increases year over year in the cost of health insurance for most Americans whether you get your insurance in the large group market or the small group market. You are still going to have a 5- to 6-percent increase in the cost of your health insurance if this bill is passed. You don't see any improvement. The best you can hope for is the status quo, which is year-over-year increases that are twice the rate of inflation. That is the impact on an average family. So the whole notion that this is going to lower health care costs just doesn't pass the truth test, according to the Congressional Budget Office.

The next promise that was made is that it would bend the cost curve down. What is interesting about that—and, of course, this was the President in the joint session of Congress on September 9 of this year:

> The plan I am announcing tonight . . . will slow the growth of health care costs for our families, our businesses, and our government.

Well, according to the Congressional Budget Office, again—and if my colleagues want to attack us, let's have them attack the Congressional Budget Office, the CMS Actuary, the Joint Tax Committee, because everything I am saying tonight I am quoting from those reports. According to the Congressional Budget Office analysis of the Reid amendment, the cost curve bends up, not down. In fact, in the first 10 years, the net increase would be about $200 billion a year in overall health care costs.

This is an outdated chart, I have to say, because this is the chart we used before this amendment was added. This is the managers' amendment, the 400-page amendment I alluded to earlier that was just added to the 2,100 page bill. In the 2,100 page bill, the Congressional Budget Office said the cost of health care in this country is going to go up, not down, by $160 billion.

So what is the cost of doing nothing? The blue line represents the cost of doing nothing. That is Federal health care spending today and what it is projected to be into the future if we do nothing. The red line, according to the Congressional Budget Office, represents what health care costs would do if the Reid bill passes. The ironic thing is that with the 400-page amendment that was added yesterday, this number gets bigger, not smaller.

I said this is an outdated chart. This only represents a $160 billion increase in the cost of health care. According to CBO's analysis on the amendment, it increases the cost of health care by $200 billion. The CMS Actuary came to a slightly different conclusion. They said health care costs would go up in the next 10 years by $234 billion. So you have all the experts—the Congressional Budget Office, the CMS Actuary—all coming to the same conclusion; that is, health care costs go up, not down. So we would have to say that is yet another broken promise.

The other thing that has been said throughout the course of this debate is that you could keep the insurance you have. In his joint session of Congress address on September 9, the President said:

> Nothing in our plan requires you to change what you have.

Well, interestingly enough, according, again, to the Congressional Budget Office, between 9 million and 10 million people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal, the Reid proposal. So we have 10 million people, according to CBO, who are going to lose their employer-based coverage, and you also have the 11 million people who get Medicare Advantage which is being cut. They aren't going to be able to keep what they have. You can argue that maybe their benefits are too rich today. That has been the argument made by the other side. But you can't say they are going to be able to keep what they have. If you are going to cut $118 billion out of Medicare Advantage, the 11 million people in this country who get Medicare Advantage are going to see their benefits cut. They are not going to be able to keep what they have.

In fact, the Senator from Pennsylvania, Mr. CASEY, said recently on these Medicare Advantage cuts:

> We are not going to be able to say if you like what you have you can keep it, and that basic commitment that a lot of us around here have made will be called into question.

Eleven million people who get Medicare Advantage aren't going to be able

to keep what they have, nor are the 10 million people, according to the CBO, who are going to lose their employer-based coverage if this plan passes—another broken promise.

No cuts to Medicare—we all know about that. We talked about that for about a week here and offered amendments to get rid of the Medicare cuts.

The President said when he was running for office:

> I want to assure [you] we're not talking about cutting Medicare benefits.

He reiterated that in his State of the Union Address.

This bill, as we know, cuts $470 billion out of Medicare in the first 10 years, and when it is fully implemented, it cuts over $1 trillion out of Medicare. In the first 10 years, $135 billion out of hospitals; $120 billion, as I said earlier, out of Medicare Advantage; $15 billion out of nursing homes; $40 billion out of home health care; and $7 billion out of hospice care—these are all Medicare cuts. These are all going to affect people in a very real way whether you get Medicare Advantage or whether you are a provider.

These are just the facts of this legislation. I am talking about the bill. I am talking about the bill, and I am talking about what the experts have said about the bill. So we would have to say, another broken promise.

The first of the last two here: open and transparent process.

We all know that when the President campaigned, he said:

> We'll have the negotiations televised on C–SPAN so that people can see who is making arguments on behalf of their constituents and who is making arguments on behalf of the drug companies or the insurance companies. And so that approach I think is what is going to allow people to stay involved in this process.

That was what the President said when he was campaigning.

We all know this bill, almost in its entirety, has been written behind closed doors. We just saw this 400-page amendment yesterday. It was interesting; earlier—it was last week, I guess—in a discussion on the floor between Senator MCCAIN and Senator DURBIN, Senator DURBIN, the No. 2 Democrat in the leadership on the Democratic side, said:

> I would say to the Senator from Arizona that I am in the dark almost as much as he is and I am in the leadership.

Even some of the leaders on the other side—there are only three people, four people sitting in a room writing this bill, and what is the most offensive thing about this came out yesterday when we found out that the Senator from Nebraska had carved out a special sweetheart deal with a goody for his State that all the rest of the States get to pay for. He gets his Medicaid for his State paid for entirely by the Federal taxpayers, and no other State gets that particular arrangement. So the Federal taxpayers in every other State, in my State of South Dakota—Nebraska borders South Dakota. I think the people in our part of the country are going to say this really smells. This is the way they are doing business in Washington, DC? This is business as usual.

The final thing I will say is this: The argument was that it won't add a dime to the deficit. Well, here I give the Democrats a little bit of credit because they did raise taxes enough and cut Medicare enough that they could actually raise quite a bit of revenue. But saying it won't add a dime to the deficit assumes there isn't going to be any payment to physicians. The physicians' fee fix, which takes about $250 billion, was completely cut out of here. They are going to have to fix that at some point. So we are not counting that.

We are counting $72 billion from a program called the CLASS Act which the chairman of the Senate Budget Committee, the Democrat from North Dakota, KENT CONRAD, called a ''Ponzi scheme of the first order,'' something Bernie Madoff would be proud of. The CBO says of the CLASS Act:

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

Even the Washington Post has editorialized about this, and they came to the same conclusion:

> The CLASS Act is a gimmick designed to pretend that health care is fully paid for.

It goes on to say:

> The money that flows in during the 10-year budget window will flow back out again. These are not savings that can honestly be counted on the budget sheet of reform.

Then we all know we have 10 years of revenue coming in, with only 6 years of spending in the first 10 years. Phony budgeting, gimmicks—all of these things are used to mask the true size of the cost of this program: $2.5 trillion over 10 years when it is fully implemented.

So if you do not use the gimmicks, if you do not use the CLASS Act, if you discount the doc fix and don't count that in there, sure, you can make it look like it doesn't add to the deficit, but the American people know better, and they have come to the conclusion this is going to add to the deficit. Even David Broder, who is the Pulitzer Prize winner for his commentary, said:

> While the CBO said that both the House-passed bill and the one Reid has drafted meet the test by being budget-neutral, every expert I have talked to says that the public has it right. These bills, as they stand, are budget-busters.

This is going to add to the deficit. These are all broken promises. That is why this bill needs to be voted down. We need to vote it down tonight. I am hoping there is a courageous Democrat or two who will join us and defeat this bad legislation and move forward to something we can pass that will meaningfully lower health care costs for the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I appreciate the chance to hear my colleague from South Dakota speak and talk about the bill. Statements he has made I am in agreement with. This is a huge bill the American public doesn't want. Gallup polling finds 61 percent of the American public oppose the Senate Democratic health care bill. In Kansas, I find widespread opposition—much higher than that. You can look at these numbers and quickly see why. Just one of the pieces of it—the Medicare cuts—will hurt Kansas. There is a 63.7-percent cut in Medicare Advantage. The benefits will affect more than 1 in 10 of Kansas Medicare beneficiaries. Those cuts are to the point that the program will no longer exist.

There is $1.5 billion in cuts to Kansas hospitals—many of our rural hospitals operating on the margins, on the edge. They get cuts. There is $239.8 million in cuts to home health agencies. This is going to put over 60 percent of them out of business in a 10-year timeframe. They don't like this. Great Christmas present.

There is an 11.8-percent cut in hospice payments. Hospice? Of all things to cut. It is a program that has been helpful to so many people late in life, and it is being cut. There is $124.2 million in cuts to skilled nursing facilities. All of those are things being cut directly to Kansans, directly to people who benefit under current programs, and this is all to start a new entitlement program—cuts Medicare and raises taxes, neither of which we can afford. Medicare is already scheduled to go bankrupt, as we well know, so this is like writing a big fat check on an overdrawn bank account and saying we will come up with the money. It is not going to work. It is going to take money from Medicare. It is going to raise taxes in a weak economy. It is going to hurt overall.

One of the issues that has come down to be one of the final pieces of this that the Democrats have put forward is the issue of funding of abortion. We have had 30 years of agreement in this body and in this Capitol that the Federal Government would not fund abortions other than in cases of rape, incest, and saving the life of the mother. That was it.

Thirty years ago, the Hyde amendment was put in place. It said we would not fund abortions. There was a big debate in the country about abortion, but there has been no debate about funding of abortion. We said we are not going to fund it. Taxpayers should not be funding abortions. If people want to do that, that is their choice on elective abortion. We are not going to fund it.

In this bill, we are going to break that amendment for the first time in 30 years.

What the President said in the joint session of Congress is no longer true. This will not be true if this passes in this bill. What the President said in the joint session of Congress:

> One more misunderstanding I want to clear up.

I was listening.

Under our plan no Federal dollars will be used to fund abortions, and Federal conscience laws will remain in place.

I point out that he said ''no Federal dollars'' and ''Federal conscience laws will remain in place.'' He said he wanted to clear up the misunderstanding. This is not the case.

We just got the managers' amendment recently, so this has been feverishly where we have had to go through what is actually in the managers' amendment. What you will find is that all the major pro-life groups are opposed to the managers' amendment because it does fund abortion. I will go through the specifics.

BART STUPAK a Democratic Member on the House side. He has been the lead guy on the House side to say we should continue with the Hyde language. There are disputes about abortions. There is not a dispute about the funding of it by taxpayer money. So BART STUPAK has led a group of Democratic Members on the issue overall and said we are going to pull it out. It is not in the House bill, but now it is in the Senate bill. He says:

Not acceptable . . . a dramatic shift in Federal policy that would allow the Federal Government to subsidize insurance policies with abortion coverage.

That is what BART STUPAK says about it. What do some of the other pro-life groups say about what is in the managers' amendment. These groups track this stuff. The U.S. Conference of Catholic Bishops, which wants a health care bill—I think they are a pretty fair reviewer of this because they want a health care bill to go through, but they are committed to life. They do not want taxpayer money to go to end a child's life. They are opposed to that—completely opposed to that on moral grounds, saying this is the highest moral order that has to be protected. Human life has to be protected, and they say, of this legislation, the managers' amendment:

This legislation should not move forward in its current form. It should be opposed, unless and until such serious concerns have been addressed.

This is on the abortion language. Now let's look at the National Right to Life Committee. The National Right to Life Committee—they are the gold standard of review. They have been looking at this issue and tracking it since Roe v. Wade was passed. They are committed to life at all stages, in all places, believing that life is sacred; it is unique; it is beautiful; and it should be protected. What do they say about the managers' amendment? They say:

Light years removed from the Stupak-Pitts amendment that was approved in the House of Representatives on November 8 by a bipartisan vote of 240–194.

The new abortion language solves none of the fundamental abortion-related problems with the Senate bill, and it actually creates some new abortion-related problems.

Let's go through the specifics, because I think what we should do is go through the specifics of this bill and look at what are the specific areas of concern. Many of the abortion changes that Senator REID smuggled into his managers' bill behind closed doors make the bill worse than ever before. It violates the Hyde amendment and Hyde principles set in precedent through all other Federal administered health programs like Medicare and Medicaid. It preempts State laws and conflicts with some existing laws on abortion.

Third is the so-called firewall. There is a firewall provision between Federal and private funds. That is inconsistent with the Hyde and Stupak-Pitts amendment. The firewall language is not very fireproof. It is a mere accounting gimmick, where they put the money in one pocket and pay for abortions from the other. It is still money that goes through the Federal Government to the Federal Government to pay for abortions.

Fourth, it departs from the way the Federal Employee Health Benefit Program is governed with respect to private plans covering abortion, so it changes that.

Fifth, it allows executive branch officials to require private health plans to cover abortions simply by defining them as ''preventive care.''

We have debated this piece calling abortions preventive care in committee and on the Senate floor. Both times we have tried to take that out and say preventive care does not include abortions, and we have not been able to get that definition to the point where abortion can still be called preventive care. This is the Mikulski amendment, which mandates that all plans cover abortion by defining abortion as a preventive service. If you just define it as a preventive service, you can pay for it. But it is still being paid for then, and that is in this bill.

No. 6, it inserts text of the Indian health reauthorization bill. That passed last year and didn't get signed into law. It passed this body. That does not contain the Senate-passed Vitter amendment to permanently prohibit coverage of elective abortions in the federally funded Indian health programs.

And, No. 7, basic conscience protections, like the Weldon language, are not included in the Senate version. There are other problems, but these are just seven of the most egregious. I can't imagine that people across the country—certainly people across my State and other places, such as Virginia, Missouri, California, Wisconsin, or anyplace else would agree that the Federal Government should break with longstanding policy against federally funded abortions, but that is exactly what has happened and what is in this bill.

Abortion is not health care. Why is it even in this bill at all? The President himself said that at the joint session of Congress.

At the end of the day, the vote for cloture is an affirmative vote for the Federal funding of abortion. There is no way around that fact. Some people on the Democratic side, particularly Senator NELSON of Nebraska, with whom I have been working closely on this issue, want to keep abortion out of this bill. I believe there are huge flaws still in it. He has been fighting to keep abortion out of it. He said this:

Taxpayers shouldn't be required to pay for abortions.

That is his statement on the issue. He says it should not be in there. He worked to try to get this out. I think there are still enormous flaws and holes in this.

If we start the funding of abortions, the last time we did fund them, over 300,000 were paid for by the Federal Government in a 1-year period of time through Medicaid Programs; 300,000 annually were funded from 1973 to 1976. How many are we looking at now if we start down this road?

We need one Democrat in the Senate who will stand and say this is not taking care of the unborn. This is breaking the Hyde language that many on the other side have supported for years, saying they are pro-choice, but they don't think the Federal Government should fund abortions. This breaks the Hyde language in the six ways I mentioned and, seven, it does not provide for conscious clause protection so someone, maybe they are in a Catholic hospital and they do not agree with providing abortion services. They would be required to do things in certain circumstances—maybe that is not one of them—but certain circumstances to which they would not agree.

This is a big part of this debate, and it has certainly elevated it here. The American public does not want the abortion language in the bill. Mr. President, 6 in 10, in a CNN survey, say they do not want it in this bill. In fact, one-quarter of House Democrats voted for the Stupak-Pitts amendment. That is the compromise that continued on the Hyde principle and said we will not fund this.

National Right to Life, I mentioned earlier, goes through some of the specifics on this language.

I will just say, where we are right now all seems so odd to me. We are in the final days of Advent season. We are here when we should be home with our families. I am missing a lot of the celebration of the Christmas season. This is the final days of Advent. Advent is the season of anticipating the birth of a child. It is a season of joy, a season of happiness. You are looking forward to the day of the birth of Christ, December 25. That is the season we are in right now. It is a season of joy. How sad we might see the end of lives of children in this bill, in this season of joy. It does not have to be that way. It should not be that way.

But now this is, I believe, the central issue in this health care debate. If this body passes this bill—and I do not think it should—it goes back to the House of Representatives, where Congressman STUPAK and a group of others

have said they will not support the language if it has the abortion language.

The issue of funding abortion has now become a central issue in the health care debate. It should not be there. It is wrong. It is opposed by the American public. I ask my colleagues on the other side, please, please, please take this out. It does not belong here. It is not the thing to do. It is harmful. It is hurtful to the country, and it does not belong anywhere near the health care bill.

I yield the floor.

Mr. McCAIN. Mr. President, much has been spoken about the need for Americans to access safe and affordable drugs and therapies. We know that the pharmaceutical industry has cut numerous deals to protect their interests and line their pockets at the expense of the taxpayers, including seniors and the uninsured. I don't think it is a secret that PhRMA cut a deal with the White House to block legislation allowing for the importation of safe and affordable prescription drugs from Canada and other approved countries. And it seems that PhRMA cut a deal to line their pockets by locking in more expensive brand drugs in the Medicare Part D doughnut hole. Finally, it appears that PhRMA made sure that their profitable biologic medicines are protected for 12 years from competition from FDA-licensed safe and affordable biosimilars.

This legislation has so many sweetheart deals that we probably haven't even found them all yet.

Today, I am filing an amendment that improves the biologic pathway in the bill. It creates a fair pathway for competitive biologics that balances incentives for innovation with patient access to safe and affordable biosimilar medicines.

It is a fact that the cost to discover biologic therapies can be astronomical. That, unfortunately, leads to some patients being unable to afford the needed therapies. Patients benefit from continued innovation but they also benefit from safe and affordable competitive biologics that may not occur under the proposal in the Reid bill. My amendment ensures that incentives to innovate remain in the law.

It is accepted that biologic therapies are different than chemical medicines. That is why there needs to be a unique structure for the approval and licensure of biosimilar medicines.

In creating a pathway to competitive biologics we need to strike a balance that provides patients greater access to more affordable, safe biologic therapies and ensures innovation continues to thrive.

Today, biologics have a monopoly for years and years. I am worried that the underlying legislation would allow biologics to game the system and block competition beyond the 12 years provided in the bill. Some have argued that brand biologic companies will be able to stack 12-year periods of exclusivity on top of each other. My amendment addresses this issue.

My amendment also addresses patient safety issues. FDA has very specific recommendations that I wanted to recognize in this pathway. Access to safe, competitive biologics is only as good as the therapies are safe. My amendment seeks to ensure the pathway for generic biologic therapies is as safe and effective as the original product.

Highlights of my amendment include 10 years of initial data exclusivity for the original product—a decade is enough. Reid—Hatch/Enzi/Hagan, has 12 years of data exclusivity. It also includes two extra years of data exclusivity if the manufacturer conducts additional research and finds new indications for the original medicine. My amendment also incentivizes additional innovation and encourages second generation therapies to come to market as soon as possible rather than companies waiting until the end of the initial exclusivity period to introduce new versions. Additionally, prescribing physician must authorize therapeutic appropriateness for a biosimilar and finally, the competitive biologic manufacturer is required to ensure the biosimilar medicine is safe and effective through clinical studies.

My goal in introducing this amendment is to ensure patient access to safe and competitive biosimilar medicines, to guarantee innovation thrives and to bring down cost while ensuring safety and innovation.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. CARDIN. Mr. President, in a few hours, we in the Senate by our votes will be able to clear the way for the United States at long last to join every other industrial nation in the world and declare that health care is a right.

I thank our leader, Senator REID, for his extraordinary courage and leadership during these many weeks as we have been able to bring together the necessary votes to move this legislation forward.

I thank Senator BAUCUS, Senator DODD, and many of my colleagues who have worked on so many provisions that are in the managers' amendment and are in the underlying bill.

For 23 years, I have been in Congress, and for 23 years I have been supporting universal coverage. I believe every American should have access to affordable, quality health insurance and health care. By our votes later on this evening, we will have a chance to take a giant step forward in accomplishing that goal.

As I pointed out, the United States, although we spend more than any other nation in the world by far on health care, whether you want to do it in absolute dollars or on a per capita basis, we spend more than any other nation. Yet we are the only industrialized nation in the world that does not provide universal insurance and universal care.

Americans have to make a difficult choice. If someone happens to be walking on the ice tonight and does not have health insurance and they fall and hurt themselves, they have to make a decision whether their arm or leg hurts badly enough to go see a doctor or perhaps to have an x-ray to see whether a bone has been broken because they do not have the money to pay for that type of care.

Many people go without checkups because they cannot afford the cost of seeing a doctor today. They do not have insurance or their insurance does not cover what they need.

Many people who are on medications have to decide whether they can split their pills to make their dollars last a little bit longer because they literally are choosing between taking their medicines or having food on the table in the United States of America in 2009, the wealthiest nation in the world.

We have a chance to change that situation. One can argue this issue on many grounds, and I have. One can argue we need to bring down the growth rate of health care costs, and I certainly believe that or one can argue that we need to provide more people with health insurance or we need to take on the health insurance industry. But I think the most persuasive argument for passing this legislation is the moral argument. It is the right thing to do. It is what America stands for.

I met with some students this week, and we were talking about the bill. These were high school students. They said it is the right thing to do, and they are right. This is the right thing for our Nation to do, to make sure everybody has access to affordable health care.

In Maryland, this takes on a special note because I know my colleagues have heard me talk frequently about Deamonte Driver, a 12-year-old who lived in Prince George's County, MD, just 7 miles from here. His mom tried to get him to a dentist because he had a toothache. They did not have insurance. No dentist would see him. After many efforts to try to get him to a dentist, he ultimately went to an emergency room. They operated on him because the tooth had become abscessed because of the delay in getting care. He needed emergency surgery. It went into his brain, and he lost his life because in the United States of America, we could not provide someone who was poor access to see a dentist. Tonight we can change that by our votes on this bill.

At long last, we have a chance to do something about that. In the last Congress, I introduced a bill that provided universal care by saying each of us has a personal responsibility to make sure we have health insurance. I did that because I think the first thing we need to do as a prerequisite to health care reform is to be sure everyone is covered, everyone is in the system.

This bill and the managers' amendment not only provides for universal coverage but makes it affordable for every person in this country.

We use the Congressional Budget Office as the objective scorekeeper. Everybody agrees to that—Democrats and Republicans. They are the professionals who tell us whether our numbers add up. The Congressional Budget Office tells us the bill with the managers' amendment will mean 31 million more Americans will have health coverage as a result of the enactment of this legislation. That will take our under 65 group from 83 percent coverage to 94 percent coverage, and for all Americans we will attain 98 percent. Sure, we want to get to 100 percent, but we are making a giant step forward for universal coverage.

The Congressional Budget Office tells us that for the overwhelming majority of Americans, they will either see no increase in their health insurance premiums from what it would otherwise be or they will see a decrease, a decline, a reduction in the cost of the health insurance premiums they would otherwise have to pay. For all Americans, they are going to have a better insurance product that is going to cover more. They are going to have less out-of-pocket costs than they would otherwise have. That is what the Congressional Budget Office tells us. Why is that true? The legislation provides for prevention and wellness. It provides that preventive services will be required to be covered in your insurance plan.

We even do that for our government programs by providing an enhanced match for States that expand the Medicaid program for our poor to cover the preventive services. It covers oral health for our children as a required part of a required essential coverage package and provides additional help to help people through education and demonstration programs.

I could give many examples, but let me give one example from the point of view of trying to expand preventive services, and that is colon cancer. We know that if you have colon screenings, you actually can discover a polyp before it becomes cancerous. You can avoid cancer. The test costs a couple hundred dollars. If you do not have a test and you have cancer and need an operation, that costs tens of thousands of dollars.

Prevention and wellness works. It brings down the growth rate of health care costs. It saves us money. This bill invests billions in prevention and wellness directly and through required coverage in our private and public insurance programs.

We bring down the growth rate of health care costs by managing complex diseases. We know we spend most of our health care dollars because of major diseases. This bill helps us manage those diseases so people can get the care they need in a more cost-effective way.

The legislation invests in health information technology so we can reduce the administrative costs of health care. I was surprised to find that Maryland, similar to most States, if you go into an emergency room, it is very unlikely they will have your medical records. If they do not have your medical records because their information technology is not sophisticated enough to get those records, then surely they are going to do tests they would not otherwise have to do, which ends up costing us all more money.

By using health information technology, we can not only take better care of you, we can do it in a less costly way. By reducing the number of uninsured dramatically, we save money. How? Because someone who is uninsured who should see a doctor or go to a clinic instead goes to an emergency room which is much more expensive. By the way, they sometimes do not pay their bills.

Each of our families, if you live in Maryland and you have insurance, you pay an extra $1,100 a year on your health insurance because you are paying for people who do not have health insurance and they access the system in a more costly way. This bill brings down the cost. You bring down the cost of health care because of competition. We believe in competition, market forces. That is what made America great.

If you live in Maryland and you have private insurance, 71 percent of Marylanders are insured by two companies. That is not competitive. I have talked with more and more business owners who tell me they have no choice. There is one plan they can get. If they do not like that plan, there is no insurance they can get. That is not competition.

This bill brings competition by the exchanges that will invite more insurance companies to participate in our States and by the program that is in the managers' package that allows us, for the first time, to have plans available across State lines. That will be particularly helpful for a State such as Maryland, where many of our employers employ people who not only live in Maryland but live in Virginia, live in Pennsylvania, live in Delaware, live in West Virginia. That will certainly help us.

This legislation also reduces our Federal budget deficit. That is a challenge. Let me tell you why it is a challenge. There are two different issues. Reducing health care cost growth and reducing Federal spending are two different issues because to get everybody insured, which will help us bring down health care costs, we need to provide subsidies so people can afford their health insurance and provide businesses some help.

As more and more people become insured, they can use our tax advantages and pay less income taxes by using before-tax dollars rather than aftertax dollars. All that costs revenue to the Federal Treasury, so it is a challenge to bring this in without adding to the deficit, but we knew we had to do that. The Congressional Budget Office, again our objective scorekeeper, tells us that in the 10-year budget window, it will reduce the Federal budget by $131 billion, but in the next 10 years, which all of us will admit is difficult to predict, they tell us we can reduce Federal spending by one-half percent of our GDP, which can translate to over $1 trillion.

My point is, we are reducing the deficit while we are reducing the growth rate of health care costs.

The Congressional Budget Office does not score us for a lot of the results from our prevention programs. They cannot assume less people will get cancer and, therefore, the preventive services will save us money. I am convinced the dollar savings will be a lot greater than that for health care costs, for our economy, and for the taxpayers of this country.

This legislation protects consumers. That is why the consumer union supports moving this bill forward. The insurance reform that is in the underlying bill is well known. I tell you, the people of Maryland want that. I am sure the people of Massachusetts also do.

The insurance reform says: Look, let's get rid of preexisting conditions. Let's not let insurance companies pick and choose whom they want to insure. They should insure everyone. The managers' package makes that available immediately for our children. We eliminate the lifetime caps, put restrictions on the annual caps. We make immediately available coverage for children under the age of 26 and provide a reinsurance program for those between 55 and 64.

We provide for an independent appeal from an insurance company's decision on coverage. Too many insurance companies have an internal mechanism to determine coverage which is stacked against the policyholder.

The managers' amendment provides for loss ratios. Loss ratios mean a certain amount of the insurance dollar must go back to pay benefits. We know a large amount is spent on advertising, spent on salaries, spent on profits. For the first time, the consumers will know how much of that is actually going to their benefits, and we start to put into law that a certain amount must be returned to the policyholders in benefits and important consumer protection information.

I am particularly pleased the Patients' Bill of Rights, an amendment I offered, is included in the managers' package. I thank the leader for including that.

In the Balanced Budget Act of 1997, a provision that I authored included a lot of the Patients' Bill of Rights in the Medicare and Medicaid Programs. President Clinton, in 1998, by executive order, extended it to all the government programs.

We passed that bill in the House and it passed in the Senate, but we never passed it in both bodies and sent it to the President the basic Bill of Rights for patients. We are making a giant

step forward in the managers' package to cover those Bill of Rights. Let me give an example. Access to emergency care that I authored is now in this bill. There are insurance companies today that tell you, you have to get preauthorization before you can go to an emergency room. Think about that. You are having chest pains and sweating and you try to find your insurance card to call your insurance company? That is not what a doctor tells you to do. You go to an emergency room.

Suppose the closest emergency room is not in your network. Does that mean you will not get full coverage? Some insurance companies say that is the case. We put in the prudent layperson standard: If it is prudent to go to the emergency room to get care, the insurance company must cover your bill.

I cannot tell you the people I talked with on both sides—I had chest pains, sweating, et cetera; I went to the emergency room, found out I did not have a heart attack and almost had one when my insurance company refused to pay the bill. I did what the doctor told me to do, and now they are not covering it. This provision will make sure that person's bill is covered.

Frankly, we have had people who delayed treatment who should have gone to an emergency room whose circumstances became much worse and some actually died. We cover access to emergency care in the managers' package, an important consumer protection.

We also allow you, as the subscriber, to determine whom you want your primary care provider to be. We give you protection as you make your decision as to whom your primary care provider will be. If you have a child, the pediatrician can be the primary care provider. If you are a woman, the OB–GYN can be your primary care provider. Many insurance companies deny you that today. That protection is in this bill for everyone.

I am also pleased to have joined Senator BROWN in a matter I worked very closely on when I was in the House for clinical trials. A lot of insurance companies today will not cover the cost of clinical trials, even though it might be the best care option available for an individual and, by the way, sometimes compromises the integrity of the clinical trial if they can't get a representative group to participate. Well, we provide protection in this bill to cover you for clinical trials that your insurance company has to cover.

So there is a lot in this bill for consumer protection—the bill of rights. Mr. President, there is a long list of organizations that support the patients' rights amendment that I offered, from the AARP, to the Consumers Union, Families USA, National Women's Law Center—all the different specialists. It is an important amendment, and I am glad to see it is in the managers' amendment.

I am proud of a major new effort that has been included in the managers' amendment. I want to talk about minority health for one moment, and I particularly want to thank a member of my staff, Priscilla Ross, who has been working on this issue for many years. She has pointed out to me the vulnerability of minority populations in America. Let me give a couple of examples.

The life expectancy for an African American is 5.3 years less than someone who is White. Minorities are two times more likely to have diabetes. African Americans have 33 percent higher death rates for heart disease than the White population. And the list goes on and on.

Access to care in the minority communities is much less than in the general communities at large. So we needed to do something about this, and the amendment I offered, which is included in the managers' package, elevates minority health in our government agencies. It provides statutory authority for the Office of Minority Health at the Department of Health and Human Services. It codifies the network of minority health offices located within the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration.

Mr. President, it elevates the Office of Minority Health at the National Institutes of Health from a center to an institute. That is making a commitment to attack this disparity that currently exists in health care in America.

Let me talk about one other issue in this bill that I am proud to work with Senator SANDERS on which involves the community health centers and primary care. Senator SANDERS was able to get $10 billion in the managers' package so that we could dramatically expand access to care. You see, if you are a Latino in America, there is a 35-percent chance you have no dependable source of health care, compared to 15 percent in the White community. We need more federally qualified health centers. You can have universal health coverage, but if you don't have facilities, it will be difficult to get access to care. The community health center expansion will provide access in underserved areas. Maryland needs this help, and there is substantial investment in primary care in this legislation.

This bill will help. It will help those who have good insurance coverage today by protecting that coverage and making sure it is available tomorrow and stopping the erosion that is taking place today with insurance companies cutting back on what is covered and employers putting more of the cost on the employee. This legislation will help. It will help small business owners who today have very little choice as to what insurance plan they can get. They are paying 20 percent more, on average, than a large company pays for the same insurance protection. This will offer choice.

We also offer tax credits to help small businesses in order to make it easier for small businesses—which are the economic engine of America—to be able to provide health benefits for their employees. It will help individuals who cannot find insurance today by having large pools they can enter without being discriminated against by the way the actuaries work and will provide subsidies for low-wage workers so they can afford the coverage.

The bill will help our Medicare population by starting to close the doughnut hole on prescription drugs, making prescription medicines much more affordable for our seniors, and providing preventative services, such as annual physicals so that seniors can stay healthy. And it provides sustainability to the Medicare Program.

Most importantly, this legislation reflects the values of our Nation—affordable, quality health care for all Americans. I am proud to support this legislation, the managers' package, and the underlying bill, and I urge my colleagues to be on the right side of history. I support moving forward with health care reform.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, thank you for the opportunity to be here this evening. I thank Senator CARDIN for a great presentation on the real facts behind this bill.

You know, being from Alaska, we see a lot of storms. We saw a great blizzard here which brought a lot of snow. I see a lot of blizzards and storms in Alaska. But I have to be honest with you, I have never seen anything like the blizzard of misinformation I have seen in Washington regarding this bill.

Over the course of the next few minutes, I want to talk about the general bill and what it means for all Americans, including Alaskans, and then specifically about the effect on Alaska.

First, I want to walk through a couple of large issues. I know people watching are hearing this over and over while we are on this bill, and the details of it, but I think it is important that we repeat it enough for people to be reminded of the positive impacts the bill will have on America and my State of Alaska. It is not a perfect bill. There are pieces I would like to have improved, and I am sure everyone in this Chamber feels the same. But it is a step in the right direction—a significant step.

On the financial end, in the first 10 years, the bill reduces our deficit by $130 billion. In the next 10 years, with the improvements in the managers' amendment and what it did for the deficit reduction, it is now $1.2 trillion—a significant impact on the national debt.

People call my office and say: How does it reduce the debt? I remind them that between Medicare, Medicaid, the VA, Indian Health Services, and many

other health care programs that we deliver, anything we do to improve the system will mean taxpayers will save money. So, again, $130 billion in the first 10 years, and the next 10 years, $1.2 trillion in deficit reduction.

The other issue—and again these are broad sweeps—is stronger medical loss ratios. This is important because this starts now, 2010, once this bill is passed, a few months after implementation. Health insurers will be required to spend more of their premiums—which really are your premiums—on clinical services and quality activities, with less going to administration—advertising, profits, excessive pay packages. If they do not adhere to the new limits, they will have to pay rebates to the policyholders. These stricter limits will continue even after the exchange starts in 2011 and apply to all plans, including grandfathered plans. That is a significant benefit to the individual—the person who has to pay the premium.

Accountability for excess rate increases: The health insurer's participation in the exchange will depend on its performance. Insurers that jack up their premiums before the exchange begins will be excluded—a powerful incentive to keep premiums affordable.

There is an immediate ban on preexisting conditions for children under the age of 18. This is in the managers' package. To me, this is unbelievable. Many families struggle, and sometimes the parents will forego their health care in order to make sure their child is as healthy as possible. But when a child has a preexisting condition, just to get coverage for them is sometimes almost impossible. So this makes sure that no insurance company can ban or deny them access to health care with preexisting conditions.

Ensuring the needy have access to care: The use of annual limits on benefits will be tightly restricted, ensuring access to needed care. And those limits will be prohibited completely by 2014. Starting in 2010, new policies will eliminate the lifetime caps.

Also, on the broader scheme, there will be innovation. Medicare will be able to test new models. I can't tell you the number of times I have had a public hearing or a public meeting in Alaska, or I have had phone calls come in from people who have asked me: Can we do something different? How can we improve Medicare? This creates some new incentives to move forward on innovation within our Medicare system.

When you look at the small business end of it, the package improves, including starting the health insurance tax credit in 2010, with almost $40 billion of tax credits. Tax savings to small business will be available.

Transparency: New requirements will ensure that insurers and health care providers report on their performance, allowing patients to make the best possible choice.

The next issue—multistate options. This is something during my campaign I talked a lot about—a program we all have in Congress, and so do almost 4 million Federal employees and their dependents. How do we replicate that to give a benefit to the taxpayers of this country, if they want to access something similar? Well, now we have the multistate option. Health insurance carriers will offer plans under the supervision of the Office of Personnel Management, the same entity that oversees the health plans of Members of Congress and for Federal employees. At least one plan must be a nonprofit, and the plans will be available nationwide. This will truly promote competition and choice for individuals.

Another new idea, which Senator WYDEN had sponsored for many months and talked a lot about, is free choice vouchers, giving more choices to individuals with their money.

As mentioned earlier, the community health centers: It is estimated this bill will now be able to put in place almost 10,000 community health centers throughout this country, providing easy and affordable access for folks.

On the small business end, I want to again just broadly sweep on this. The credits will be available on a sliding scale to small businesses, those small businesses with fewer than 25 employees, and average annual wages of less than $50,000. All small businesses will truly benefit, but if you are a small business with 50 or less employees, you will be exempt. If you want to provide insurance to your employees, and you are in a small group of 25 employees or under, there will be credits available for you.

The bill also clarifies part-time because we have so many part-time employees who work within the seasonal businesses in Alaska—retail, fishing, tourism. It makes sure that small businesses are not hampered by this legislation but enhanced. Again, 96 percent of the small businesses will be exempt from this law, unless they decide to provide health care, and then they can get some benefits through tax credits—up to $40 billion available.

I am a member of a group of freshmen who came to Washington this cycle. We came with all kinds of ideas on how we wanted to change Washington in short order. We sat down with this bill in mind, and as a group of freshmen, we put together a cost containment package with many ideas—very technical in a lot of ways, but just in the broader sense, it creates administration simplification. It helps ensure we go after health care fraud. With regard to Medicare system upgrades, we make sure that as we develop new systems for Medicare and for the providers, we do some pay-for-performance testing, which will save individuals, save Medicare, and save the Medicare system over time.

The freshmen spent many weeks on the cost containment package we put together, and I want to give credit to Senator WARNER for leading the charge, though everyone participated to try to make a difference and bring cost containment to the issue of health care.

I want to go through a quick list on this broader perspective of the legislation and what happens now, because we hear always from the other side that so many things are delayed way out; that they will not happen right away. Let me walk through several items that happen right away.

The Senate bill will make it illegal for insurance companies to drop coverage for Americans who are sick—basically, they call them rescissions—beginning 6 months after the date of enactment. Insurance companies will be barred from limiting the total benefits Americans can use over the course of a year—otherwise known as lifetime caps—beginning 6 months after the date of enactment. Affordable insurance coverage options will be made available for high-risk pools of Americans who have been uninsured and have been denied coverage because they have preexisting conditions, effective 90 days after enactment.

Early retirees between 55 and 64: I hear from a lot of them who are trying to figure out, as they are now retired and still have some coverage from their former employer, but it is expensive. What this does is set up a new program, and access to a program that will reduce their premiums beginning 90 days after enactment. Insurance companies will be required to start posting their overhead costs on a public Web site so consumers can better compare the deal they are getting effective July 1, 2010.

Insurance companies will have to start providing external review processes beginning 6 months after the date of enactment. Dependents will be able to receive coverage up to the age of 26 on their parents' policy, beginning 6 months after the date of enactment.

This is one again I hear so much when I am back home and from e-mails and letters, people wanting to keep their kids on their policy. Again, coverage up to the age of 26.

The insurance companies will be required to begin covering preventive services and immunization without copays on payments beginning 6 months after the date of enactment. Seniors will have access to dramatic discounts in the purchase of name brand prescription drugs in the Medicare Part D Program beginning July 1.

As I said earlier, children under age 18 cannot be denied for preexisting coverage.

There will be free preventive services for seniors—$500 reduction in the doughnut hole for seniors.

Again, the issue with Medicare, I want to say, when we started this effort to reform health care, Medicare was in trouble and could be in serious trouble by 2017. This legislation adds 10 more years to Medicare.

To be specific to Alaska—and I will be brief on this but I think it is important—many of these issues I laid out

are important to Alaska, but there are quite a few very specific. First, I remind folks what the impact is currently in Alaska—133,000 Alaskans do not currently have insurance; 27,000 residents who now buy expensive individual premiums will now get affordable coverage. We double enrollment in Alaska's Kid Care, what we call here in Washington SCHIP, to more than 15,000 young people, ending the hidden tax on families. About $119 million is spent on uncompensated care, averaging about $1,900 per year. By creating a larger program as we are doing here, we can eliminate that cost.

I have heard over and over about Medicare Advantage. Let me tell you how that works for Alaskans. What we will be doing, we have 60,000 Medicare beneficiaries paying a price for excessive overpayments in higher premiums, even though 99 percent of our Alaskan seniors do not participate in Medicare Advantage.

What you hear when you hear about Medicare Advantage—and those who have it I am sure enjoy it—but in my State we are subsidizing that even though 99 percent of Alaska seniors do not take that program. So we pay an extra approximately $90 to subsidize that program for those extra things they claim they have. The reality is that was supposed to be run by the private sector, saving money to Medicare. It is now costing us more, it is costing my State $90 per Medicare family.

About 10,600 Alaskans hit the doughnut hole in Alaska through the Medicare drug coverage, which can cost some of our seniors up to $4,000 additional a year. They will see a 50-percent reduction.

As I mentioned under early retirees on the national program, 7,300 Alaskans will be affected in a positive way; 8,600 Alaska small businesses could be helped by the small business tax credit. Again, Alaska is benefiting a great deal from this legislation.

Even more specific—and these are items I added specifically in the bill to focus on Alaska's specific issues. I thank Senator HARKIN on this next one, which is important. It is providing more primary care providers. It is a loan repayment program. I know he has been an advocate of getting more primary providers within the system—physicians, nurse practitioners, physicians assistants—from $3,500 to $5,000 for the National Health Service Corps in this country. It serves health professional shortage areas, including 77 in Alaska.

In part, because of this, and due to other major expansion, the Senate HELP Committee has estimated the bill will attract 24,000 new primary care providers. If you want to make a difference to the health care system, this is one critical piece. Again, Senator HARKIN, I know, has been an advocate for this for many years. To see us get to this state and be able to move this forward is significant. It will have a positive impact.

Another one which is a program that is a great benefit for hospitals in Soldotna, Juneau, and Sitka, is an amendment which reauthorizes a Medicare project supporting hospitals in rural communities in smaller States, extending that for an additional 5 years, moving it from 10 States to 20 States and creating another 15 hospitals that can participate.

Alaska health care task force—specifically in this legislation, to deal with our Medicare provider issue in Alaska but also our TRICARE, making sure we deliver the right kind of hospital and medical care to our veterans.

More physicians assistants—we inserted specific language to make sure we allow loan repayments for physician assistant teaching faculty, to be also included in loan forgiveness. Last year we had 375 PAs who handled 1.2 million office visits in Alaska.

After 21 years, the Indian Health Service is now in this bill to be reauthorized. For 21 years it has not been reauthorized.

There are many great things in this legislation, from a broader perspective, as I mentioned earlier in my comments, but also very specific to Alaska.

Could it be better? Absolutely. But do we think we have a piece of legislation that is going to make an impact on people's lives? Yes, we do. If we want to keep it the same old business as usual, I guarantee, in 5 years or 10 years from now we will be in this hall, trying to figure out what to do at a bigger crisis.

This is the right decision. It will be an honor for me later this evening to make a vote in the affirmative to move past the cloture vote, getting on to voting for this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, first I thank the Senator from Alaska for all of his hard work on this bill. I think it is fair to say the Senator from Alaska, a new Member of the Senate, I might add, has been very much involved in this bill and his focus has been on rural health and better health care for native Alaskans. As the Senator knows, the Indian Health Care Improvement Act, which also covers Native Alaskans, is included in this bill. I thank the Senator from Alaska for insisting on that and for being a strong supporter of making sure we do help primary care practitioners, both doctors but also nurse practitioners, physicians assistants, other health care and primary health care people who are going to serve in our small towns and rural communities. The Senator from Alaska has been one of our best leaders on making sure that we have this in the bill. I thank him for that very much.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. NELSON of Florida. Mr. President, I have been listening on C–SPAN 2, in addition to having the privilege of being over here on the floor, to this debate that has been going on. The debate has been going on ever since the summer when we in the committee were fashioning this legislation. I must say that to hear one side of this debate, I would not recognize all of those hearings we had last summer and all the markup we did in the Finance Committee last September because what has been presented to the Senate, and what has been presented to the public through press conferences by the opposition to this bill in most cases simply is not correct.

I want to give a couple of examples here this evening. In attacking this, saying what dastardly things this is going to do for the country and how this is going to increase costs and raise taxes—each one of these things can be refuted. But it is a typical tactic that, when you want to attack something and tear it down, you go after a specific item instead in order to obfuscate, which then misses the point of the whole piece of legislation.

The point of the whole piece of legislation is to make health care available and affordable, in most cases through health insurance, in other cases through Medicare and Medicaid, and making it available, efficient, and affordable.

I want to give one specific example. It is a technical term in the insurance industry called the ''medical loss ratio.'' It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. It is interesting that the term medical loss ratio tells you a lot about the insurance industry, because if you look at it only from their perspective, this percentage is their loss but in fact the percentage is the amount of the premium dollar that goes to actual medical care. What this amendment, this managers' amendment we are going to vote on in less than 2 hours right now says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar.

Let me give an example. This is an example of the medical loss ratio of a number of small employers—small employers, that is group policies—as well as policies in the individual market. This is where you have an employer who pays for your health insurance but it is a small employer, usually under 50 employees.

This is where you have policies that are given to individuals. The premiums usually are much higher if you are an individual buying insurance than if you are buying it in a group, by an employer-sponsored group.

These are specific examples in a particular year of the loss ratio. Interestingly, for Aetna, here, at 82 percent—that is not actually a loss to Aetna. It is interesting they call it a loss. That is actually 82 cents of premium dollar,

an insured policyholder's premium dollar, that actually goes to medical coverage. That is good.

United Health: 79; Humana, down at 77—77 cents of that $1 are going to health care.

And the balance, 23 cents, is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit. What does the bill do? The bill brings that up to 80 percent. And that is all policies, not just the new policies on the health insurance exchange. That is not just the policies insurance companies are going to write new for the small group. It is all those policies that are in existence.

Look at the individual. The experience isn't quite as good. As a matter of fact, here is a company, Coventry, that was only paying 66 cents on every premium dollar that was actually going to health care, and the rest of that, 34 cents, was going to profit and administrative expenses and executive salaries and bonuses and so forth. And lo and behold, what we are going to vote on tonight in less than 2 hours is going to have to be 80 cents on every dollar. If they don't make that 80 cents on every dollar, they are going to get penalized. We are putting some real teeth in this on insurance companies for the first time.

Look at the large group, the employer-sponsored insurance, the large group. These are five of the larger insurance companies. You can see they have a pretty good record thus far: WellPoint, 85, Humana, 82 cents on every dollar. They have a better record because they have a lot more individual lives over which they can spread the insurance risk, and so they can pay out more in health insurance for health care and take out less for administrative expenses. But in this bill tonight, in an hour and 45 minutes, we are going to raise that to 85 percent, 85 cents on every dollar.

Before I came to the Senate—and I have had the good fortune of serving the public for now going on over 35 years—I had the privilege of being elected to one of the toughest jobs I have ever had in a lifetime of public service, and that was the elected insurance commissioner of Florida. It is also the elected treasurer. That position has morphed into what is called the chief financial officer. It is a member of the Florida cabinet. For 6 years, I got to see what insurance companies will do. I can tell you, instead of 85 percent and 80 percent that we are going to require in this bill of every insurance premium dollar they pay out in medical care, I can tell you that some of the insurance companies I regulated back in the State of Florida were down in the sixties. A lot of that was going into big-time administrative offices, all kinds of jets, all kinds of padded expense accounts. You can see what we are trying to do here with this bill tonight.

Let's ask, why do we have to have a ratio such as this and why is it important? It certainly is getting more medical care to the individual policyholder. But listen to this: A study that was done by the Senate Commerce Committee shows that the ratios are often below what is considered to be fair. Our Commerce Committee found that in the small business market, those with fewer than 50 employees, insurers spend only 79 cents out of every dollar on health care. That is in the Commerce Committee study. In the individual market, it is even worse. It is 74 cents. In the individual market, the insurer keeps more than a quarter of every individual premium dollar for overhead and profit.

We need to ensure that the policyholder's premiums and the Federal subsidies that are going into the purchase of private health insurance on the exchange are used for actual medical care and not for wasteful administrative spending and marketing and profits. If we don't do this kind of thing, regulating insurance companies, then they are going to take advantage. They are going to take the advantage of making more money at the expense of patient care.

I want to give an example. In spite of this recession, this economic recession we are in and the increasing unemployment over the past year, what has happened to the big insurance companies? They are posting big profits. They seem to be making more money by insuring fewer people. The only way you make more money with fewer customers is you get rid of your less profitable customers—in other words, the sick ones. That is called cherry-picking. You pick the good risks, which are the healthy ones, and you try to get rid of the sick ones.

Let me give some examples. In the second quarter of this year, 2009, the largest health insurance company, UnitedHealth Group, announced a 3-month profit of $859 million in one quarter, and it more than doubled the profits from the previous year. UnitedHealth earned these record profits in spite of the fact that it was insuring 600,000 fewer people than it did a year ago.

Let me give another example. In the second quarter of this year, another large insurer, CIGNA, saw its profits jump 60 percent to $435 million. CIGNA earned these healthy profits in spite of the fact that it is insuring 200,000 fewer people than a year ago.

Another example: In the second quarter of 2009, Humana saw its profits rise 34 percent to $282 million. Humana earned those healthy profits in spite of the fact that it was insuring 100,000 fewer people than a year ago.

At the same time they are dropping beneficiaries, insurance companies are paying their CEOs record salaries. In 2008, Aetna's CEO earned over $24 million. That is the equivalent of more than $66,000 per day. If you want to know where some of that administrative padding that is not coming back to the policyholder in health care is going, there is a good example. Aetna's CEO earned over $24 million in that 1 year, 2008.

This medical loss ratio we are building into this bill on which we will vote shortly builds on other insurance provisions in this legislation which include guaranteed issue, which include prohibiting cancellations, banning preexisting conditions so that they can't terminate you or not insure you because they cook up some excuse, some flimsy excuse. I am not sure this has been brought out in this debate, but I think it is worthy of consideration by the Senate.

In my closing minutes, I want to now step back and look at the overall package. Why is this a good deal for America, and why is it going to pass with an extraordinary threshold of 60 votes tonight? Because we are not going to allow in this legislation excessive rate increases in the health insurance exchange that is created new, that is going to insure 31 million new people. A lot of those people are people who don't have insurance now. A company will be banned from that health insurance exchange if it starts jacking up its rates excessively. You talk about an insurance commissioner's dream, a regulator's dream—often your hands are tied and you are put into a straitjacket by the insurance laws of your State and you can't crack the whip on them. We are cracking the whip on them in this legislation.

There has been a lot of talk about the program on Medicare other than Medicare fee-for-service called Medicare Advantage and how it is going to be whacked. I can tell you, for my State of Florida, there are 950,000 senior citizens on Medicare Advantage, and it is not going to be whacked. There have been a lot of statements out here by people attributing it to Florida, that it was going to be cut. In this bill we are voting on tonight and whenever we go to final passage, it is not.

By the way, there was a statement made here and something that was entered into the RECORD, a letter from a cardiologist from Jupiter, FL, who was complaining about how cardiologists' fees are being squeezed and they may not be able in the future to take care of Medicare recipients. I happen to know about this. I have been trying to help the cardiologists. But it was stated out here on the floor of the Senate that it is this bill that is doing that. That has nothing to do with this legislation. That has to do with the administrative functions of government in existing law, CMS, that, in my opinion, has used incomplete data to cut cardiologists, particularly that are needed in a State such as Florida where, in fact, so many senior citizens are needing the service in Medicare of cardiologists.

Here is another major thing in this bill. We are setting up a nationwide insurance plan that will be sold on these health insurance exchanges, and it will be operated by the Office of Personnel

Management, the same office that governs the health insurance of Federal employees and Members of Congress.

There is a part in this bill on tort reform. It sets up State grants to test alternatives to litigation.

In my remaining minute, let's don't forget the 31 million more people who are going to come in insured and how this, over time, is going to bring down the cost of Medicare. It is not going to cut Medicare. It is going to save Medicare. It is going to do that with efficiencies such as electronic records and accountable care organizations and emphasis on primary care physicians.

To conclude, what else does the bill do? It lowers the deficit over the next 10 years by $132 billion. In the second 10-year period, it is going to lower it by up to $1.3 trillion. That is serious deficit reduction.

On that happy note, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Let me thank Senator NELSON for his strong commitment to Medicare. I know of no Senator who fights harder for Medicare and for making prescription drugs more affordable to seniors than the Senator from Florida. He has contributed his great expertise as a former insurance commissioner to the provisions we have in this bill on cracking down on insurance company abuses, and he just went through some of them there. I thank my good friend Senator NELSON from Florida for all of his great input into this bill.

In a few minutes, the Senate will close its doors for a brief recess. When those doors reopen just after midnight, the Senate will reconvene for a historic purpose: to bring the promise of quality, affordable health care to millions of Americans. When those doors reopen, we who have the privilege of serving in this body will have the opportunity to vote for hope and opportunity and new help for working families who worry every day that their illness will cause them to go bankrupt.

Mr. President, I yield the floor.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3284. Mr. GREGG 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 3285. Mr. GREGG 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 3286. Mr. GREGG 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 3287. Mr. GREGG 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 3288. Mr. REID 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 3289. Mr. REID submitted an amendment intended to be proposed to amendment SA 3288 submitted by Mr. REID and intended to be proposed to the 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 3290. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3291. Mr. REID submitted an amendment intended to be proposed to amendment SA 3290 submitted by Mr. REID and intended to be proposed to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3292. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3293. Mr. MCCAIN 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 3284. Mr. GREGG 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, insert the following:

TITLE ____—HEALTHY MOTHERS AND HEALTHY BABIES

SEC. __01. SHORT TITLE.

This title may be cited as the ''Healthy Mothers and Healthy Babies Access to Care Act''.

SEC. __02. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON WOMEN'S ACCESS TO HEALTH SERVICES.—Congress finds that—

(A) the current civil justice system is eroding women's access to obstetrical and gynecological services;

(B) the American College of Obstetricians and Gynecologists (ACOG) has identified nearly half of the States as having a medical liability insurance crisis that is threatening access to high-quality obstetrical and gynecological services;

(C) because of the high cost of medical liability insurance and the risk of being sued, one in seven obstetricians and gynecologists have stopped practicing obstetrics and one in five has decreased their number of high-risk obstetrics patients; and

(D) because of the lack of availability of obstetrical services, women—

(i) must travel longer distances and cross State lines to find a doctor;

(ii) have longer waiting periods (in some cases months) for appointments;

(iii) have shorter visits with their physicians once they get appointments;

(iv) have less access to maternal-fetal medicine specialists, physicians with the most experience and training in the care of women with high-risk pregnancies; and

(v) have fewer hospitals with maternity wards where they can deliver their child, potentially endangering the lives and health of the woman and her unborn child.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. __03. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any obstetrical or gynecological goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any obstetrical or gynecological-related human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of obstetrical or gynecological goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) obstetrical or gynecological goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a physician or other health care provider who delivers obstetrical or gynecological services or a health care institution (only with respect to obstetrical or gynecological services) regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider who delivers obstetrical or gynecological services or a health care institution (only with respect to obstetrical or gynecological services) regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider who delivers obstetrical or gynecological services or a health care institution (only with respect to obstetrical or gynecological services), including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) obstetrical or gynecological services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this title, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) OBSTETRICAL OR GYNECOLOGICAL SERVICES.—The term ''obstetrical or gynecological services'' means services for prenatal care or labor and delivery, including the immediate postpartum period (as determined in accordance with the definition of postpartum used for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)).

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider who delivers obstetrical or gynecological services or a health care institution. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. __04. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this title applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. __05. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing

in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations provided for in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. __06. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. __07. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. __08. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __09. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. __10. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section __05(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __12. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3285. Mr. GREGG 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 80, line 22, strike ''and''.

On page 80, after line 25, add the following:

''(i) adherence to or participation in reasonably designed programs of health promotion and disease prevention, if such programs exist; and''.

On page 81, line 4, insert before the period the following: '', except that group health plans and health insurance issuers offering group or individual health insurance coverage may establish premium discounts or rebates for modifying otherwise applicable copayments or deductibles in return for adherence to or participation in reasonably designed programs of health promotion or disease prevention''.

Beginning on page 84, strike line 15 and all that follows through line 3 on page 94, and insert the following:

''(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

''(1) GENERAL PROVISIONS.—

''(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

''(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

''(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

''(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

''(A) A program that reimburses all or part of the cost for memberships in a fitness center.

''(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

''(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under an individual or group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

''(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

''(E) A program that provides a reward to individuals for attending a periodic health education seminar.

''(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described

in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

''(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

''(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. The plan or issuer shall evaluate the program's reasonableness at least once per year.

''(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

''(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

''(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

''(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

''(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

''(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

''(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

''(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

''(l) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.''.

SA 3286. Mr. GREGG 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 114, beginning with line 17, strike all through page 116, line 6, and insert the following:

(e) CATASTROPHIC PLAN.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if the plan provides—

(1) except as provided in paragraph (1), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(2) coverage for at least three primary care visits.

On page 155, beginning with line 22, strike all through page 156, line 3, and insert the following:

(A) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan.

On page 250, lines 7 through 10, strike '', except that such term shall not include a qualified health plan which is a catastrophic health plan described in section 1302(e) of such Act''.

SA 3287. Mr. GREGG 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, insert the following:

SEC. ___. PREVENTING THE GAMING OF THE 10 YEAR BUDGET WINDOW.

Section 402 of the Congressional Budget Act of 1974 5 (2 U.S. C. 653) is amended—

(1) in paragraph (2), by striking ''and'' after the semicolon;

(2) in paragraph (3), by striking the period and insert ''; and''; and

(3) by inserting at the end the following:

''(4) for any provisions with delayed effective dates or phase-in periods, an estimate of the costs for the year that the provision first becomes fully effective and for each of the following 9 fiscal years.''.

SA 3288. Mr. REID submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the amendment, insert the following: The provisions of this section shall be effective upon enactment.

SA 3289. Mr. REID submitted an amendment intended to be proposed to amendment SA 3289 submitted by Mr. REID and intended to be proposed to the 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:

In the amendment, strike ''upon enactment'' and insert ''5 days after enactment''.

SA 3290. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the language proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

SA 3291. Mr. REID submitted an amendment intended to be proposed to amendment SA 3290 submitted by Mr. REID and intended to be proposed 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 orded to lie on the table; as follows:

In the amendment, strike ''upon enactment'' and insert ''5 days after enactment''.

SA 3292. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the amendment, insert the following:

This section shall become effective 5 days after enactment.

SA 3293. Mr. MCCAIN 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 1859, strike line 6 and all that follows through line 5 on page 1906, and insert the following:

Subtitle A—Patient Access to Safe and Competitive Biologics

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ''Patient Access to Safe and Competitive Biologics Act''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR THERAPEUTICALLY EQUIVALENT.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR THERAPEUTICALLY EQUIVALENT.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) conducted by the applicant that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, after public notice and comment, that an element described in item (aa) or (bb) of clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

''(B) THERAPEUTIC EQUIVALENCE.—If a sponsor submits an application (or supplement to an application) under this subsection claiming that the biologics product is therapeutically equivalent to the reference product, such application (or supplement) shall include information demonstrating that the biological product meets the standards described in paragraph (4)(A).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4)(A), and therefore is therapeutically equivalent to the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING THERAPEUTIC EQUIVALENCE.—

''(A) DETERMINATION BY THE SECRETARY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to have demonstrated therapeutic equivalence to the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(i) the biological product—

''(I) is biosimilar to the reference product; and

''(II) can be expected to produce the same clinical result as the reference product in any given patient; and

''(ii) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(B) APPLICATION OF THERAPEUTIC EQUIVALENCE ONLY WITH PRESCRIPTION.—Notwithstanding any other provision of law, no biological product determined to be therapeutically equivalent to a reference product under subparagraph (A) shall be deemed to be therapeutically appropriate with respect to an individual unless so determined by a health care professional treating such individual.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(6) EXCLUSIVITY FOR FIRST THERAPEUTICALLY EQUIVALENT BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of therapeutic equivalence for any condition of use, the Secretary shall not make a determination under paragraph (4)(A) that the second or subsequent biological product is therapeutically equivalent for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first biosimilar biological product to be approved as therapeutically equivalent for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved therapeutically equivalent biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved therapeutically equivalent biosimilar biological product; or

''(C)(i) 42 months after approval of the first therapeutically equivalent biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first therapeutically equivalent biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—

''(i) IN GENERAL.—Except as provided in clause (ii) and (iii), approval of an application under this subsection may not be made effective by the Secretary until the date that is 10 years after the date on which the reference product was first licensed under subsection (a).

''(ii) EXTENSION OF EXCLUSIVITY.—The period of exclusivity described in clause (i) for a reference product shall be extended for an additional 2 years beyond the 10 years provided in such clause if the sponsor or manufacturer of the reference product submits a subsequent application for a change (not including a modification to the structure of the reference product) that results in a new indication for the reference product.

''(iii) SIGNIFICANT THERAPEUTIC ADVANCEMENT.—If a reference product represents a

significant therapeutic advancement (including a modification that results in a new dosage form, new dosing regimen, or new route of administration of such biological product) of a biological product that was previously licensed under subsection (a) and that has the same sponsor or manufacturer as such reference product, then the period of exclusivity for such reference product shall be the number of years equal to the sum of—

''(I) the remaining period of exclusivity under clause (i) for biological product on which the reference product representing the significant therapeutic advancement was based, plus

''(II) 2 years.

''(iv) NO EXTENSION FOR SIGNIFICANT THERAPEUTIC ADVANCEMENT.—In no case may the period of exclusivity under clause (iii) be extended.

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—The date on which the reference product was first licensed under subsection (a) does not include the date of approval of a supplement or of a subsequent application for a new indication, route of administration, dosage form, or strength for the previously licensed reference product.

''(8) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4)(A).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(l) PATENTS.—

''(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

''(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the 'subsection (k) applicant') and the sponsor of the application for the reference product (referred to in this subsection as the 'reference product sponsor'), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

''(B) IN GENERAL.—

''(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the 'confidential information').

''(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

''(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the 'outside counsel'), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

''(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

''(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

''(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

''(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

''(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

''(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

''(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

''(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

''(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

''(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

''(3) LIST AND DESCRIPTION OF PATENTS.—

''(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

''(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

''(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

''(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

''(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

''(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

''(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

''(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

''(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

''(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

''(4) PATENT RESOLUTION NEGOTIATIONS.—

''(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

''(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

''(5) PATENT RESOLUTION IF NO AGREEMENT.—

''(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

''(B) EXCHANGE OF PATENT LISTS.—

''(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

''(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

''(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

''(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

''(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

''(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

''(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

''(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

''(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

''(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

''(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

''(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

''(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

''(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

''(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

''(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

''(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

''(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

''(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

''(ii) not included, as applicable, on—

''(I) the list of patents described in paragraph (4); or

''(II) the lists of patents described in paragraph (5)(B).

''(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

''(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

''(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

''(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

''(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).

''(4) The term 'therapeutically equivalent' or 'therapeutic equivalence', in reference to a biological product, means that such product has been determined to meet the standards described in subsection (k)(4).''.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by adding ''or'' at the end; and

(iii) by inserting after subparagraph (B) the following:

''(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

''(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,''; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product'';

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking ''and'' at the end;

(ii) in subparagraph (C), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking the period and inserting '', and'';

(iii) by inserting after subparagraph (C) the following:

''(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.''; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking ''and (C)'' and inserting ''(C), and (D)''; and

(C) by adding at the end the following:

''(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

''(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

''(ii) for which an action for infringement of the patent with respect to the biological product—

''(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

''(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

''(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

''(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.''.

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: '', or section 351 of the Public Health Service Act''.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: ''or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies''.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

''(n) NEW ACTIVE INGREDIENT.—

''(1) NON-THERAPEUTICALLY EQUIVALENT BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for therapeutic equivalence with the reference product, shall be considered to have a new active ingredient under this section.

''(2) THERAPEUTICALLY EQUIVALENT BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is therapeutically equivalent with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.''.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking ''section 351'' and inserting ''subsection (a) or (k) of section 351''.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(i) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) ALTERATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) ACCOUNTING STANDARDS.—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United State Code, to ensure the validity of any potential variability.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

''(m) PEDIATRIC STUDIES.—

''(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7)(B) are deemed to be 4 years and 6 months rather than 4 years and the date that is 6 months after the date described in subsection (k)(7)(A) rather than the date described in such subsection; and; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7)(B) are deemed to be 4 years and 6 months rather than 4 years and the date that is 6 months after the date described in subsection (k)(7)(A) rather than the date described in such subsection; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.''.

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting '', biological products,'' after ''including drugs''.

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

''(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Patient Access to Safe and Competitive Biologics Act and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

''(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

''(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.''.

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar or therapeutically equivalent to, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the period of exclusivity described in subsection (k)(7)(A) of such section 351.

RECESS UNTIL 12:01 A.M. TOMORROW

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

Under the previous order, the Senate stands in recess until 12:01 a.m., Monday, December 21, 2009.

Thereupon, the Senate, at 11:31 p.m., recessed until Monday, December 21, 2009, at 12:01 a.m.

Daily Digest

Senate

Chamber Action

Routine Proceedings, pages S13557–S13637

Measures Considered:

Service Members Home Ownership Tax Act: Senate continued consideration of 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, taking action on the following amendments proposed thereto: **Pages S13558–S13628**

Pending:

Reid Amendment No. 2786, in the nature of a substitute. **Pages S13558–S13628**

Reid Amendment No. 3276 (to Amendment No. 2786), of a perfecting nature. **Page S13558**

Reid Amendment No. 3277 (to Amendment No. 3276), to change the enactment date. **Page S13558**

Reid Amendment No. 3278 (to the language proposed to be stricken by Amendment No. 2786), to change the enactment date. **Page S13558**

Reid Amendment No. 3279 (to Amendment No. 3278), to change the enactment date. **Page S13558**

Reid Motion to commit the bill to the Committee on Finance, with instructions to report back forthwith, with Reid Amendment No. 3280, to change the enactment date. **Page S13558**

Reid Amendment No. 3281 (to the instructions (Amendment No. 3280) of the motion to commit), to change the enactment date. **Page S13558**

Reid Amendment No. 3282 (to Amendment No. 3281), to change the enactment date. **Page S13558**

Amendments Submitted: **Pages S13628–37**

Recess: Senate convened at 1 p.m. and recessed at 11:31 p.m., until 12:01 a.m. on Monday, December 21, 2009.

Committee Meetings

(Committees not listed did not meet)

No committee meetings were held.

House of Representatives

Chamber Action

The House currently stands in recess. The House is scheduled to meet at 11:30 a.m. on Wednesday, December 23, 2009.

Committee Meetings

No committee meetings were held.

Joint Meetings

No joint committee meetings were held.

COMMITTEE MEETINGS FOR MONDAY, DECEMBER 21, 2009

(Committee meetings are open unless otherwise indicated)

Senate

No meetings/hearings scheduled.

House

No committee meetings are scheduled.

Next Meeting of the SENATE

12:01 a.m., Monday, December 21

Senate Chamber

Program for Monday: Senate will continue consideration of H.R. 3590, Service Members Home Ownership Tax Act, and after a period of debate, vote on the motion to invoke cloture on Reid Amendment No. 3276 (to Amendment No. 2786) at approximately 1 a.m.

Next Meeting of the HOUSE OF REPRESENTATIVES

11:30 a.m., Wednesday, December 23

House Chamber

Program for Wednesday: To be announced.

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