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House of Representatives

The House was not in session today. Its next meeting will be held on Tuesday, October 20, 2009, at 12.30 p.m.

Senate

MONDAY, OCTOBER 19, 2009

The Senate met at 2 p.m. and was called to order by the Honorable MARK R. WARNER, a Senator from the Commonwealth of Virginia.

PRAYER

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

Let us pray.

O God, You are our refuge. When we are exhausted by life's efforts or bewildered by life's problems or wounded by life's sorrows, we come to You for shelter.

Strengthen our lawmakers for their challenging work. When their tasks are beyond their power and duty calls for more than they have to give, renew them with Your might. Help them to believe in Your power and to be certain that You are able to do for them above all that they can ask or think. Strong Deliverer, be for each of them a strength and shield in these momentous times.

We pray in Your sovereign Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK R. WARNER led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, October 19, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK R. WARNER, a Senator from the Commonwealth of Virginia, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. WARNER thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

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

HEALTH CARE REFORM

Mr. REID. Mr. President, fixing a system so badly damaged by decades of mismanagement and manipulation is not an easy task. It is no secret that health care is no exception.

We are not doing it simply to keep us busy; that is, legislate on health care. We have a bevy of other backbreaking problems that have piled up over the past 8 years—everything from energy, to education, to Wall Street abuses—only to be passed on to this Congress and the Obama administration.

Nor are we doing it because the health insurance industry wants us to do it; just the opposite. In fact, they are doing all they can to protect their reckless policies and raging profits.

We are doing this legislating on health care because the American people demand that we do it. Families of all backgrounds and from every State are counting on us to act. Last November, it was one of the primary reasons they called on Democrats to correct our country's course.

The American people are closely watching this debate. They are listening to the policies being proposed, and they can see the strategies employed toward those ends. They are watching, and here is what the American people are saying in response: Nearly two-thirds of them know Republicans are not working in good faith with Democrats to reform America's broken health insurance system.

They are right. While we have made every effort to create a good bill that can earn the support of as many Senators as possible, Republicans have made every effort to stop any bill, regardless of what is in that bill.

How do we know this? We know this because Republicans have offered no ideas for reform. We know this because while they talk in the abstract about proposals, they have yet to offer any of their own. But, most of all, we know this because Republicans say it themselves.

In August, the junior Senator from Arizona predicted that almost all Republicans would oppose health insurance reform, regardless of any concessions Democrats made.

Then the senior Senator from Oklahoma said—and I quote—

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

I don't have to read it, or know what's in it. I'm going to oppose it anyways.

Then I opened this morning's Roll Call newspaper—this newspaper that covers Congress—and read a disturbing headline, one that confirms what nearly two-thirds of the American people already know and should convince the rest. It reads: ''GOP Launches Strategy to Trip Up Health Bill.''

If Republicans truly want to legislate, shouldn't this headline read ''GOP Launches Strategy to Improve Health Bill''? Wouldn't we all benefit from the GOP launching a strategy to strengthen the health bill? Wouldn't it be better for the millions who fear losing their health insurance, and for the millions who do not have any to begin with, if we would open the morning newspaper and read even this: ''GOP Launches Strategy to Contribute to Health Bill''? But, no, none of that.

The truth is that they have no interest in improving or contributing to health reform and strengthening it or contributing to its improvement in any way. Instead, Republicans have one strategy—and one strategy alone—support the broken status quo.

Republicans want to ''trip up'' our plan to protect what works about the system, fix what does not, and help the middle class get ahead. That is because they do not mind the fact that insurance companies can deny you coverage when you need it the most or because you have a preexisting condition, defined as anything from high cholesterol to hay fever to heart disease to diabetes.

Republicans want to ''trip up'' our plan to stabilize health insurance for those who have it and help secure it for those who do not. That is because they think it is OK for insurance companies to raise your rates just for getting old or because your dad had prostate cancer or because you are a woman.

Republicans want to ''trip up'' our plan to keep the insurance industry honest and to protect Medicare. That is because they support a status quo that forces families fortunate enough to have health insurance to pay an extra $1,000 or more every year to cover all other families who have none.

Republicans want to ''trip up'' our plan to lower costs for families and make sure every American can afford good quality care that can never be taken away. That is because they simply do not have any ideas for helping the American people—even people in their own States—who are suffering so desperately.

Republicans will do everything in their power to stop reform this time because for many on the other side, there will never be a good time to reform health insurance.

That is not what our constituents sent us here to do, and that is not how to legislate.

I spent this past weekend in Nevada and heard firsthand from people who are suffering. Today we learned our State's unemployment rate rose again. One example: It is not a bunch of people out of work or people who do not have good jobs who are complaining about health insurance. I did an event in a hotel in Reno, NV—the largest and I think probably the most successful resort in northern Nevada. Of course, when I asked for questions, a number of the questions dealt with health care.

As I walked out, the owner of the property walked alongside of me and said: Senator, I want you to know that other than my cost for personnel—my wages for my employees—health care is the one issue that is so hurting my business, health insurance for my employees. I am going to keep it, but it is so difficult for me to do so.

Here is a man who has probably 1,500, 2,000 people who work for him. Think what it is like for someone who has 25 or 50 or 75 or 100 people. If someone who has the buying power of a couple thousand is having difficulty, think what it is like for people who do not have that buying power.

So this past weekend in Nevada, I really did hear from people who are suffering. Today, we learned that our State's unemployment rate rose again—another tenth of a percent. That tells me we do not have time to waste with people looking to ''trip up'' recovery. Instead, we need legislators willing to work with us toward solving problems.

Here is an opportunity. Republicans can show they are willing to do more than simply stand in the way. We are working this week to protect seniors' relationships with their doctors. One of the biggest fears of seniors is that their doctors will drop them, which is why we are proposing a bill to make sure doctors will continue to see their Medicare patients.

This is a very serious issue. It is not one that is made up. There are ads running around the country today. There is one that says: ''If You Don't Pass S. 1776, Seniors Will Lose.''

Seniors count on their doctors to get the care they need to stay healthy. The Medicare Physician Fairness Act (S. 1776)—

That is the legislation I am talking about—

preserves the doctor-patient relationship and protects seniors' access to their doctors. AARP is fighting to ensure that doctors will continue accepting patients on Medicare.

Ninety percent of AARP members agree with this. This is a real problem. Because of some of the things done with Medicare legislation in the past, a number of doctors have decided they cannot afford to take Medicare patients. This will drive another 40 percent of the doctors away from Medicare. It will destroy Medicare. So it is important we work together to get something done to take care of this. That is because the status quo simply will not work.

We are working, as I said, this week to protect seniors' relationships with their doctors. One of their biggest fears is that their doctors will simply drop them, which is why we are proposing this bill to make sure doctors will continue to see Medicare patients.

Republicans have come to the Senate floor numerous times in recent weeks to demand that Congress protect seniors. This so-called doctors fix that AARP is running the ads about is an opportunity for Democrats and Republicans to work together to improve Americans' health. This time it is seniors' health.

The AARP has 40 million members. Nine out of 10 of them support this legislation—90 percent of them. I hope Republicans will listen to the very people whom they claim to defend and support—seniors.

While, generally speaking, the Republican strategy is disappointing, to say the least, it is not entirely surprising. After all, one Republican Senator—I do not know if he is speaking for the entire Republican Senate—is on record hoping health insurance reform will be President Obama's ''Waterloo.'' Nor is it inconsistent with the obstructionist tactics that have denied and delayed so many other important efforts to address so many of our critical challenges.

Democrats have been consistent in our efforts to reach across the aisle. In April of this year, just as the health care debate was beginning, I wrote my counterpart, Leader MCCONNELL, to express my great hope that Republicans would work with us in this important and historic endeavor. We have an opportunity this week to fulfill that request I made. Here is what I wrote on that occasion:

In order for this bipartisan process to take root, Republicans must demonstrate a sincere interest in legislating. Rather than just saying no, you must be willing to offer concrete and constructive proposals.

I concluded the letter by writing:

I hope your conference will recognize that this issue is too important to be manipulated for political purposes.

So it is now about a half a year later. It is clear Republicans have not heeded our gesture. It is equally clear to the American people, two-thirds of whom readily recognize that Republicans have no interest in returning the favor—not in the least.

As former Senate Majority Leader Bob Dole said a few days ago—and I quote—

Sometimes people fight you just to fight you.

That might be true, but it will not be tolerated. Congress will not be sidetracked by those who devise strategies only to ''trip up'' progress, rather than to contribute in good faith. This country has no place for those who hope for failure.

Mr. President, I suggest the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

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

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

HEALTH CARE WEEK XIV, DAY 1

Mr. MCCONNELL. Mr. President, I don't know of a single person who wants to see reimbursements cut to doctors who treat Medicare patients, but if Congress is going to step in and prevent it, we shouldn't do it by racking up more debt on the government's credit card.

On Friday, the Treasury Department announced that the government ran a deficit of $1.4 trillion in the fiscal year that ended just a few weeks ago—a deficit about three times the size of the previous alltime high. This should have been a wake-up call but, instead, within days of the sobering proof of Congress's chronic inability to live within its means, Democrats in Congress want to borrow another $¼ trillion to keep doctors from getting a pay cut. Republicans want to fix this problem as well, but there are ways to pay for it. When this matter comes before the Senate, Republicans will offer ways to pay for it without asking taxpayers to take on another $¼ trillion in debt.

It is perfectly obvious why Democrats want to resolve this issue outside the larger debate over health care. They are doing it so they can say their health care plan doesn't add to the deficit. It is a gimmick and a transparent one at that.

Americans are tired of gimmicks and tired of Congress putting everything on the national charge card. We are not teenagers. Our parents aren't going to pay our bill at the end of the school year. The American people—our children and grandchildren—are the ones getting stuck with the bill. It is time we act as if we are aware of that.

Higher debt is just one aspect of the Democrats' health care plan that concerns Americans. At the outset of this debate, everyone agreed on one thing: Any reform would have to address the primary problem with health care; that is, cost. Yet every day we hear about some accounting gimmick that is being used to conceal the true cost of this bill, and now we are hearing it will drive up premiums as well.

The Director of the independent, nonpartisan Congressional Budget Office, Doug Elmendorf, indicated in recent congressional testimony that parts of the Finance Committee proposal would lead to higher premiums; in other words, that health care costs would go up, not down. As a result of the Democrats' latest health care proposal, that is exactly what will happen. This is a proposal that is only going to get more expensive as the process moves forward in closed-door discussions between a handful of Democratic lawmakers and the White House. This is what the American people have feared all along, that lawmakers would lose sight of the purpose of reform and end up making problems worse, not better.

The Finance Committee bill includes a new tax on health insurance that most experts, including the CBO, agree would be passed straight to consumers, leading to higher premiums. One estimate suggests this new tax on insurance plans will be passed on to families, costing them nearly $500 per year in higher premiums starting next year, long before any of the purported benefits of reform would take effect. The Oliver Wyman Group, an international management consulting firm, has also looked at how the Finance Committee bill would impact premiums in a number of States. This is important because every State has different insurance laws. In States such as Kentucky, Arizona, and Virginia, which have flexible insurance laws and generally lower premiums, the impact would be dramatic.

Currently, the average family premium in those States is about $9,500 a year. Under the Baucus plan, that premium is expected to rise to nearly $17,000. That is $7,500 more that the government is telling families they have to spend on health insurance. That is $7,500 these families can't use for the college fund or to plan for retirement. While the Baucus plan may subsidize some insurance plans, the subsidies likely will not be enough to offset these massive new costs imposed on many of these families.

The bottom line is this: The Finance Committee bill has now been out for a few weeks. The experts are starting to estimate what it would mean for insurance premiums. What we have seen so far isn't good. This is precisely why Americans want us to debate these bills out in the open. This is why they want us to take our time until the true cost is known. This is why they should have ample time to look at proposed changes before Congress acts.

We knew this proposal would raise taxes. We knew it would slash Medicare. Now we know it will raise health insurance premiums. Americans support reform, but higher premiums, higher taxes, and cutting Medicare, that is not reform.

GAG RULE

Mr. President, the administration made a noteworthy admission over the weekend. In a late afternoon memo on Friday, the Department of Health and Human Services said health plans could now communicate with seniors about pending legislation that affects them. By lifting its prior ban on communicating the impact of Democratic plans for health care, the administration was admitting—admitting—the ban amounted to a gag rule, a gag rule that has no place in a society that prizes free speech and open debate. The administration's reversal is certainly welcome and, frankly, not unanticipated. However, many questions remain about the initial order itself and about the administration's willingness to constrain the free flow of information to seniors about their health care. The administration has admitted its error, though its proposed solution, frankly, needs further review.

The fact is, what health plans were telling seniors is precisely what the Congressional Budget Office also said; namely, that Democratic health care plans could cause seniors with Medicare Advantage to lose benefits—the absolute truth.

Americans believe strongly in the importance of the first amendment. I am glad to see the administration has recognized the error of its ways and rescinded this gag rule in the midst of such an important national debate.

I suggest the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

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

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

RESERVATION OF LEADER TIME

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

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. The Senate will be in a period of morning business until 4:30 p.m., with Senators permitted to speak for up to 10 minutes each.

The Senator from Arizona is recognized.

START TREATY

Mr. KYL. Mr. President, I wish to speak to an issue that is very timely because the United States and Russia are beginning today their seventh round of negotiations on the so-called START treaty. This is a treaty that could limit the number of nuclear warheads and delivery vehicles by both countries and provide an extension of various compliance and verification procedures that are currently followed by both countries.

It is interesting to me that the Russians do not appear to be in much of a hurry to complete the negotiations before the treaty expires, and it expires on December 5 of this year. According to Assistant Secretary of State Richard Verma, in a letter to me and several fellow Senators, I quote:

> Russian views with respect to the meaning of these two terms—

And he is specifically talking about the definitions of ''strategic delivery vehicle'' and ''associated warheads,'' both of which are obviously key to the treaty, in any event—

> Russian views with respect to the meaning of these two terms have not yet been fully explained by the Russian Federation.

We are in the seventh round of negotiations, as I said. When these two fundamental terms have not yet had an

explanation by the Russian side as to what they mean and, in effect, what they are tabling in the way of proposals, it is pretty clear we are not far enough down the road to see much light at the end of the tunnel.

With regard to the verification rules, which are the heart of the START treaty, he wrote:

The Russian Federation has not, as yet, elaborated sufficiently on its views concerning verification for the United States to judge the nature of its approach.

Again, it is interesting that this letter, which is dated October 5, suggests the Russians had not yet provided to us their position on key provisions of this treaty. Yet we are supposed to have the negotiations completed before the treaty expires on December 5.

It is increasingly clear to me, as a result of all this, there will not be a treaty by December 5; certainly not one that is ratified by the Senate, which is a process the Senate will require several months, obviously, to complete. As I said, I think it is doubtful we will even see one signed by the United States and Russia by December 5.

It is clear to me the Russians have sensed an opportunity that they can use time to their advantage. They saw an overly ambitious American agenda, which went far beyond extending the compliance and verification measures of the existing treaty to actual proposals to significantly cut the numbers of warheads and delivery vehicles. They saw this obviously ambitious agenda pushing up against a very short timeframe—in this case December 5. I think they have cleverly manipulated the situation, among other things, by throwing additional subjects into the mix, such as missile defenses and advanced conventional modernization and our nonnuclear conventional strike capabilities. By throwing these things into the mix, they have created a situation where it is going to be impossible to conclude negotiations by December 5, at least if the United States wants to stand firm on its position that neither the conventional strike capability nor missile defenses should be a subject of these negotiations.

I think the Russians think they can scoop up a bunch of concessions from the United States because of this short timeframe and the fact that the United States will obviously want to conclude the negotiations, if they can, by December 5. I think an example of concessions would be the recent decision of the United States to leave ourselves more exposed to a long-range missile threat from Iran as a result of taking out the so-called missile shield we had previously committed to the countries of Poland and the Czech Republic. I think the Russians may have correctly assessed that the Obama administration would be willing to make trades such as the one on European missile defense in order to get nuclear force levels lower because this would show progress on President Obama's agenda for a nuclear weapons-free world. At the same time, the Russians are attempting to constrain the United States.

It is interesting they are actually developing programs, systems that would be prohibited by the START treaty. One is the RS–24 multiple warhead ballistic missile, which the Russians tested as recently as May 29, 2007. That would be illegal for the Russians to deploy under START. So why are they testing it? They seem very happy to negotiate for fewer missiles because they would be able to add multiple warheads on the missiles they have.

That is known as MIRVing or the multiple reentry vehicles. You just add more warheads on the same missile and you can accomplish the same thing, as if you had more missiles with an individual warhead on each one. It is clearly not progress, especially since the purpose of START, among other things, is to promote greater stability, which comes from reducing the number of multiple-warhead weapons.

If the administration had simply limited the agenda to preserving and continuing the START treaty verification measures, we probably could have met the December 5 deadline and we could have preserved the treaty and avoided issues such as missile defense that have now been raised by the Russians.

Although the Senate will have to participate in this ratification process—and very soon, quite possibly—we really have no idea yet how the administration will deal with the expiration of START on December 5. What options does it have in mind to deal with that expiration date? How will it seek to extend the treaty? What are the legal consequences for information sharing and inspections both here and in Russia? What are the separation-of-power issues of the various approaches having to do with a treaty ratified by the Senate which expires, with the administration making treaty-like commitments to continue abiding by the treaty during the course of time prior to the Senate's ratification of the treaty? All of these are questions to which we have not gotten answers. Yet time is wasting.

Several of my colleagues and I have asked for the answers to these questions in our August 14 letter to Assistant Secretary Gottemoeller. The October 5 response from Mr. Verma ignored the questions about the expiration date, and we need the answers.

Beyond December 5, getting a new treaty ratified is not going to be an easy proposition. Many Members of the Senate have been clear that because the administration is seeking nuclear force reductions, it must concomitantly take responsibility for the nuclear forces that will remain. We will have fewer of them. We need to know that they will work and that they are safe.

Of course, both of these issues are related to the nuclear posture review, which isn't really due until January. But since the administration rushed to its analysis to justify warhead and delivery vehicle reductions, it must now act quickly to assemble a comprehensive modernization plan that includes warheads, the nuclear weapons complex, and delivery systems. That plan has to be presented to the Senate no later than when they send the treaty up to the Senate, and the fiscal year 2011 budget will need to be sent at roughly the same time because it is the first year of the effectuation of the plan they would be presenting. Presumably, the plan will encompass maybe, let's say, a decade of nuclear weapons complex modernization, but next year's budget will really be the first time we will be able to verify the administration's seriousness about this modernization effort.

So as to ensure there is no doubt on what ''comprehensive modernization plan'' means, let me refer to the definition provided by the Perry-Schlesinger Congressional Commission on the Strategic Posture of the United States. The essential elements of such a program identified by the Perry-Schlesinger Commission are, first, full and timely Lifetime Extension Programs for the B61 and W76 warheads consistent with our military needs; second, funding for a modern warhead that includes new approaches to life extension involving replacement or, possibly, component reuse; third, full funding for stockpile surveillance work through the nuclear weapons complex as well as the science and engineering campaign at our National Laboratories; fourth, full funding for the timely replacement of the Los Alamos plutonium research and development and analytical chemistry facility, the uranium facilities at the Oak Ridge Y–12 plant, and a modern pit facility. These are the essential components the President needs to present. It is the minimum that should be included.

I might add that this is already required as part of the fiscal 2010 Defense Authorization Act I presume this body will soon pass and send to the President's desk. If anything short of this is submitted, the resulting delay in consideration of the treaty will be through no fault of the Senate; instead, blame will be with the administration and its failure to heed numerous admonitions from Senators. We needed this plan submitted at the same time as the treaty.

It goes without saying that the administration must also understand that any limitations on U.S. missile defense or nonnuclear global strike capability will also be a deal breaker in the Senate.

Finally, I will refer again to the issue of Russia's multiple-warhead RS–24. In this case, it appears the Russians have cheated—if not in the letter of the START agreement, at least in its spirit—by converting one of their existing missiles, the TOPOL-M, to this new multiple-warhead variant.

However, if you look at the 2005 Section 403 Report, which is also known as

the Adherence to and Compliance With Arms Control, Nonproliferation, and Disarmament Agreements and Commitments report, prepared by the State Department's VCI Bureau, there are a litany of other outstanding issues regarding Russia's failure to comply with START.

In fact, to quote from the 2005 report:

A significant number of longstanding compliance issues that have been raised in the START Treaty's Joint Compliance and Inspection Commission remain unresolved.

Mr. President, I ask unanimous consent to have printed in the RECORD at the conclusion of my remarks the portion of the 2005 report dealing with Russia's noncompliance with its obligations under the 1991 agreement.

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

(See exhibit 1.)

Mr. KYL. Mr. President, it is clear that the administration needs to tell the Senate whether this 2005 finding is still valid. In fact, I think the administration owes the Senate answers to the following questions:

When will the State Department submit the next section 403 compliance report?

Will the Senate see it before being asked to provide advice and consent on the START follow-on agreement? If not, why not?

Does the State Department expect the compliance issues with the 1991 agreement to be resolved prior to the expiration of that agreement?

Does the State Department expect the follow-on agreement to include a mechanism for swift resolution of compliance issues? Have our START negotiators proposed such a mechanism? If so, can the negotiators brief the Senate, either in open Senate or a closed venue, on how it would work?

I encourage the administration to provide answers to these questions soon. The longer it takes to receive answers, the more it appears there is something to hide. Senators will want to know why we should ratify a new treaty when the administration is not enforcing provisions of the existing treaty.

Mr. President, keeping START from expiring without replacement should not have been such a difficult matter. I regret that choices made by the administration have made it so. I encourage the administration to respond to the inquiries I have raised today, respond to the letters, the correspondence we have sent, and be able to provide to the Senate the answer to the key question: Why would we be asked to ratify a new treaty when we have not enforced compliance with the treaty it would seek to replace? All of these questions, as well as the requirement that a new modernization program be submitted, at the latest, at the same time the treaty is submitted, are important requirements for the Senate to provide its advice and consent with respect to a new START treaty.

I yield the floor.

EXHIBIT 1

ADHERENCE TO AND COMPLIANCE WITH ARMS CONTROL, NONPROLIFERATION, AND DISARMAMENT AGREEMENTS AND COMMITMENTS

III. OVERVIEW

EXPANSION OF START COMPLIANCE SECTION

Section 403 of the Arms Control and Disarmament Act—the legislative basis for the submission to Congress of this series of Noncompliance Reports—requires that the Report provide greater specificity about compliance concerns. To wit, the law requires the Report to include ''a specific identification, to the maximum extent practicable in an unclassified form, of each and every question that exists with respect to compliance by other countries with arms control, nonproliferation, and disarmament agreements with the United States.'' To comply with this requirement, this edition of the Report has included more information than ever before on, among other things, Russia's implementation of the Strategic Arms Reduction Treaty (START).

To facilitate this effort, in 2003 the United States conducted consultations with the Russian Government regarding a number of longstanding, unresolved U.S. concerns about Russian compliance with the START Treaty—some of which actually date back to the first year of START implementation. These included Russia preventing U.S. inspectors from measuring the launch canisters of certain Intercontinental Ballistic Missiles (ICBMs) or verifying that certain ICBMs do not contain more warheads than attributed under the Treaty. The U.S. concerns also included Russia failing to provide all required telemetry materials for some START-accountable flight tests, failing properly to declare certain ICBM road-mobile launchers accountable under the Treaty, and locating some deployed SS–25 ICBM launchers outside their declared restricted areas. With respect to this last issue, however, it should be noted that Russia has taken steps that have resolved U.S. compliance concerns.

V. COMPLIANCE BY SUCCESSORS TO TREATIES AND AGREEMENTS CONCLUDED BILATERALLY WITH THE SOVIET UNION

THE STRATEGIC ARMS REDUCTION TREATY (START)

Belarus, Kazakhstan, Russia, and Ukraine are in compliance with the START strategic offensive arms (SOA) central limits. Both the United States and Russia met the START seven-year reduction final ceilings of 1,600 delivery vehicles and 6,000 attributed warheads by the December 4, 2001, deadline. By December 2001, these four Former Soviet Union (FSU) successor states had reduced their aggregate forces to 1,136 deployed launchers, 5,518 deployed warheads, and 4,894 deployed ballistic missile warheads, as defined by Article ll of the Treaty, and all strategic weapons had been removed or eliminated from the territories of Ukraine, Belarus, and Kazakhstan. Additionally, START required the four FSU successor states to eliminate at least 154 heavy ICBM (SS–18) silo launchers by December 2001. In the original MOU, dated September 1, 1990, the Soviet Union declared 308 SS–18 heavy ICBM silo launchers. As of November 30, 2001, a total of 158 SS–18 silo launchers had been eliminated—104 in Kazakhstan and 54 in Russia—leaving a total of 150 deployed heavy ICBMs.

Notwithstanding the overall success of START implementation, a significant number of longstanding compliance issues that have been raised in the START Treaty's Joint Compliance and Inspection Commission (JCIC) remain unresolved. The Parties continue to work through diplomatic channels and in the JCIC to ensure smooth implementation of the Treaty and effective resolution of compliance issues and questions.

The United States raised six new compliance issues during the period of this report. The United States considers four of these to have been closed. However, several previous—often long-standing—compliance issues remain unresolved. A number of these issues, some of which originated as early as the first year of Treaty implementation, highlight the different interpretations of the Parties about how to implement the complex inspection and verification provisions of the START Treaty.

ICBM ISSUES

Inability to Confirm during Reentry Vehicle Inspections (RVOSIs) that the Number of Attributed ICBM Warheads Has Not Been Exceeded. During RVOSIs of deployed Russian ICBMs, U.S. inspectors have been hampered, in some cases, from ascertaining whether the missile had a front section, or that the front section contained no more reentry vehicles (RVs) than the number of warheads attributed to a missile of the declared type under the Treaty.

The purpose of an RVOSI, as set forth in paragraph 6 of Article XI of the Treaty, is to confirm that a ballistic missile contains no more RVs than the number of warheads attributed to a missile of that type. The RVOSI procedures are referenced in paragraph 16 of Section IX of the Inspection Protocol and contained in Annex 3 to the Inspection Protocol. Paragraph 11 of Annex 3 allows the inspected Party to cover RVs. Inspectors have a right to view these covers and to measure hard covers prior to their placement on the RVs. The covers are then installed on the RVs before the inspectors view the front section. Under the Treaty, such covers must not hamper inspectors in ascertaining that the front section contains no more RVs than the number of warheads attributed to a missile of that type. Russian RV covers, in some instances, are too large; consequently, they fail to meet this requirement.

During certain RVOSIs, Russia did not demonstrate to the satisfaction of the U.S. inspection team that additional covered objects located on the front section, and declared by Russia not to be RVs, were not RVs. Although START does not differentiate between nuclear and non-nuclear RVs, Russia's willingness to use radiation detection equipment (RDE) during such RVOSIs to establish that the extra objects were not nuclear has been useful for resolving some, but not all, U.S. concerns.

Finding Russian RV covers, and their method of emplacement, have in some cases hampered U.S. inspectors from ascertaining that the front section of the missiles contains no more RVs than the number of warheads attributed to a missile of that type under the Treaty. Russian cooperation in the use of RDE and other measures has been helpful in addressing some, but not all, of the difficulties encountered by U.S. inspectors.

Russian Road-Mobile Launchers—''Break-in.'' Russia has failed to declare certain road-mobile launchers of ICBMs when they first leave their production facility, as required by the Treaty. Russia has moved some of these launchers to an undeclared ''break-in'' area located over 60 miles from the production facility without declaring that they have left the production facility and are accountable under the Treaty.

Pursuant to paragraph 6(b) of Article III of the Treaty, a mobile launcher of ICBMs becomes subject to the Treaty limitations when it first leaves a production facility.

Not later than five days following the first exit of such a newly produced non-deployed road-mobile launcher, and its entry into Treaty accountability, Section I of the Notification Protocol requires the Party producing the new Treaty-accountable item to provide a notification of this change in data. Except for transits, Parties are proscribed from locating non-deployed mobile launchers outside the boundaries of the START-declared facilities identified in subparagraph 9(b) of Article IV of the Treaty.

Finding. Russia continues to violate START provisions relevant to these obligations.

Deployed SS–25 Road-Mobile Launchers Based Outside Their Designated Restricted Areas. Russia based some deployed SS–25 road-mobile launchers outside their declared restricted areas (RAs) at two road-mobile ICBM bases while these RAs were under construction. The United States and Russia concluded a temporary, interim policy arrangement regarding the conduct of inspections and cooperative measures at the facilities where the launchers were housed during the period of construction. This arrangement permitted U.S. inspectors to conduct data update inspections and RVOSIs that they had not previously been able to perform, and allowed Russia to cooperate fully with providing cooperative measures access for the launchers that were previously unavailable. All of these road-mobile ICBMs and their launchers have since been transferred from their bases, and their declared RAs have been eliminated as START facilities.

Finding. Notwithstanding the interim policy arrangement, Russia's practice of locating deployed SS–25 road-mobile launchers outside their declared RAs for long periods of time constituted basing in a manner that violated the provisions of paragraphs 1 and 9 of Article VI of the Treaty. This practice has ceased and the United States considers this issue closed.

Denial of the Right to Measure Certain Deployed ICBM Launch Canisters on Mobile Launchers. U.S. inspectors have been prevented from exercising the Treaty right to measure certain ICBM launch canisters on mobile launchers, both deployed and non-deployed, that are encountered during data update inspections to confirm data regarding the type of item of inspection. Russia, for instance, has prevented U.S. inspectors from measuring launch canisters for SS–24 ICBMs contained in rail-mobile launchers that are located within the boundaries of an inspection site. Similar concerns have arisen with regard to launch canisters for SS–25 and SS–27 mobile ICBMs located on road-mobile launchers. With regard to launch canisters for these latter types, Russia and the United States have agreed upon a policy arrangement to address this issue, though it has not yet been implemented for the SS–27 ICBM.

Subparagraph 20(a) of Section VI of the Inspection Protocol identifies ICBM launch canisters as one of the items of inspection for data update inspections. In accordance with the procedures in Annex 1 to the Inspection Protocol, inspectors have the right to confirm the number and, if applicable, the types of items of inspection that are specified for the facility to be inspected and declared for the inspection site, and the right to confirm the absence of any other item of inspection at the inspection site. Pursuant to paragraph 6 of Annex 1, inspectors may view and measure the dimensions of a launch canister declared to contain an item of inspection to confirm it is of the declared type.

Finding. Russia prevented U.S. inspectors from exercising their Treaty right to measure launch canisters for SS–24 ICBMs contained in rail-mobile launchers that are located within the boundaries of an inspection site, in contravention of paragraphs 1 and 6 of Annex 1 to the Inspection Protocol. With regard to launch canisters for SS–25 and SS–27 ICBMs located on road-mobile launchers, the Parties have agreed upon a policy arrangement to address this issue, but it has not yet been implemented for the SS–27 ICBM.

TELEMETRY ISSUES

As part of the START verification regime, the Parties are obligated to notify each other of missile flight tests and to exchange telemetry tapes, tape summaries, interpretive data, and acceleration profiles for each flight test of a START-accountable ICBM or SLBM. The United States has raised several concerns regarding Russia's failure to provide all Treaty-required telemetry materials for some START-accountable flight tests in violation of paragraphs 4 and 5 of Article X of the Treaty, and paragraph 1 of Section I and paragraphs 1 and 2 of Section II of the Telemetry Protocol.

Finding. Russia has in some instances failed to comply with Treaty requirements regarding the provision of telemetry information on missile flight testing pursuant to Article X of the START Treaty and Sections I and II of the Telemetry Protocol.

Mr. KYL. Mr. President, I suggest the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

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

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

HEALTH CARE REFORM

Mr. KYL. Mr. President, I believe my colleague, Senator THUNE from South Dakota, will be here in a few minutes. Until he arrives, I thought this might be of interest. I promised my constituents I would tell my colleagues what they told me to tell them. I think it would be of interest to share some of these remarks.

I went to a meeting on Saturday morning that I thought was going to be a rather staid affair with folks who were primarily senior citizens, but not all of them were. It turned out to be a little bit reminiscent of some of those townhall meetings we saw on television during August because the subject most people wanted to talk about was health care. They weren't happy with what they were hearing the Senate was about to do. Among other things, they wanted to get it clear with me right off that I would pass on their concerns about this to my colleagues. I promised that I would. So let me summarize what some of them had to say and what I think the clear consensus of the group was.

First of all, they have a hard time understanding how Senators would pass a bill before we read it or even know how much it costs. I assured them that the procedure we would follow in the Senate was that we would have at least 72 hours after the bill had been finally written and after the Congressional Budget Office had scored the bill—that is to say, told us how much it would cost in all of its component parts and the ways it would be paid for. The reason I can feel fairly certain that will happen is because a number of colleagues on both sides of the aisle have either written to the majority leader or made it clear to him that they will not support a motion to proceed to a bill until we have had an opportunity to, in effect, read it and see how much it costs. That process could take some time, I told my friends. The Congressional Budget Office Director told the members of the Finance Committee, on which I sit, that it can take 2 to 3 weeks after the bill is written to come up with all of these calculations.

You will hear many people say we need to move this process on, even before we have the numbers. But I think that given the fact that most of us are committed to ensuring we have the numbers and can digest them and share them with our constituents before we debate and amend the bill, I assume the process will unfold in the Senate in such a way that we do know what it costs, and that means after the final CBO report is provided to us.

The next thing they wanted me to convey was that they were very worried about—in fact, maybe that would be a euphemism. They were more than concerned about the degree of government involvement in health care once this process is over. They fail to understand why we had to have what amounts to a government takeover of insurance in this country and dictating everything from what kind of insurance policy you have to have, to how doctors and hospitals are paid, in order to solve the two key problems that exist: No. 1, there are some Americans who need help buying insurance; second, that the costs of health care premiums continue to go up every year, and it is especially hard for small businesses to provide coverage for employees.

They asked me: Why do we have to change the entire system, with the government essentially taking it over?

I happen to believe we don't. I provided the two basic alternatives to them. One is a step-by-step approach that targets specific problems we have and matches up specific solutions to the problems, on the one hand, which is the approach I favor; on the other hand, essentially changing the insurance we all have today, creating a new insurance exchange, and all insurance would have to go through there. Even if you like your policy, it will change, and you are not going to be able to keep it.

Estimates are that, as a result of all of this, in an effort to cover 18 or 20 million more people with insurance, it is going to cost us close to a trillion dollars. It will raise taxes, it will raise insurance premiums, and it will require deep cuts in Medicare. They didn't like that. I guess that brings up the third thing.

With regard to Medicare, they were pretty perceptive in asking me the following basic question. One person said: One of two things is going to happen. Either it will be business as usual where we say we will make cuts in Medicare, but the Senate and the House never have the courage to do that, in which case this bill is going to cost a lot of money that is not offset by concomitant savings, or the savings are going to be made, and when they are made, it is going to deeply cut our benefits under Medicare.

That person was right. One of those two things is true, and neither one is a good result.

I remember a few years ago when we tried to reduce the growth in Medicare by about $10 billion. Republicans and President Bush were excoriated; we were going to ruin Medicare, and our colleagues on the Democratic side took great glee in the public reaction to that proposal to decrease the growth in Medicare by $10 billion.

Now we are talking about cutting Medicare by—I said $500 billion. The Finance Committee money is actually $450 billion. So let's be accurate. If that is the way this bill comes out, $450 billion, $120 billion of that is reduction of benefits under Medicare Advantage. So when people say: You would not have your benefits cut, that first $120 billion is a direct cut in benefits, and in my State a lot of seniors have Medicare Advantage policies.

The other way in which Medicare is cut—there are basically two things. One is reducing the amount of money we pay doctors and hospitals, and that cannot help but reduce the care we get. The final mechanism is a Medicare Commission is being established to provide—I think it is every year; maybe every 2 years, but let's say every year—an amount of money that will have to be cut and will automatically be cut from Medicare unless the Congress finds a different way to do it, but Congress would still have to cut the same amount. So we either do it the way we want to do it or we do it the way the commission recommends it. In any event, their recommendation automatically goes into effect if Congress does not act.

I have a couple thoughts about that point. We have never been able to effect these cuts in the past because seniors know that it cuts deeply into their care, and they have told us and we have reacted by saying: OK, we will not do it. We could react that way again, in which case all of the savings, or at least a great deal of the savings, that were supposed to result and offset the costs of the bill would not be there. So now the bill is no longer deficit neutral. Now it is not balanced. Now it does add to the deficit and to the debt. If we do allow those cuts to go into effect, seniors are clobbered by deep reductions in the care they receive all the way from nursing homes to physicians to hospitals to hospice, medical devices—you name it. As I said, neither of these results is a good result.

There were several people who wanted me to convey their thoughts in that regard. I happen to agree with them, so I could do that.

I met, after visiting with this group, with a group of spinal surgeons from all over the country and, in fact, from outside this country. I saw the agenda of their meeting. I was the last speaker. For a layman, such as you and I, Mr. President, it was daunting to read through that agenda—all of the latest techniques in using new laser and stints and all kinds of things that I did not understand, but it was the very latest technology and techniques for treating spinal diseases and conditions.

What they told me was—I was the last person to make a presentation—all of these great things we are doing for our patients we are not going to be able to do under this legislation, first of all, because it will be presumed to cost too much; second, because it will take the FDA and the other government agencies way too long to authorize its use for treating Medicare patients, for example; and, third, because the comparative effectiveness research which has in the past been used by these doctors to help them appreciate the best way, clinically, to treat someone is now going to be used to decide what Medicare can afford to pay. A lot of the more leading-edge techniques and technologies are not going to be approved for that purpose.

Their point was that people in China and Europe are going to be treated with the latest techniques more than Americans will because the American system of health care is going to deny people such as these experts the ability to do what they do.

One way this is being accomplished is by taking money away from specialists and giving it to general practitioners. There is a rationale for paying general practitioners—family doctors—more money. They are not making enough, and they are the first place most of us enter the medical world. If we have something that does not feel right, we go to our doctor. It is usually a family doctor. Frequently, he can help us, but frequently he says: I think there is something about what you have here that tells me I have to send you to a specialist. We go to the specialist then and he orders some specialized tests and he examines them and he may end up having to provide some kind of very specialized treatment and care that is probably going to cost more money.

While the family doctor needs to be paid more, we don't solve that problem by taking money away from the specialists. If we have to add money to the system to ensure that we have enough doctors who can provide quality care, then there is no free lunch and we have to pay for what we get. We should not make it a zero-sum game and take it from Dr. B in order to pay Dr. A. That was another strong message of these specialists.

I also happened to meet on Friday afternoon with a group of physicians in Phoenix from all different practices—from specialists to generalists, hospital physicians to others. To a person, they had this question for me. The way they asked it was, Why isn't anybody talking about medical malpractice reform?

I said: I am talking about medical malpractice reform.

They said: You are not getting through.

I said: The problem is there are a bunch of folks on the other side of the aisle who don't want medical malpractice reform, and you know why. And, yes, they understood the answer why.

I remind friends who might not have remembered, Howard Dean, a former Governor of Vermont and a former Democratic candidate for President and a former Democratic Party chairman was very candid in a townhall meeting in Northern Virginia on August 17 with Representative MORAN where he told the group assembled there that the reason medical malpractice reform was not in the legislation is because they did not want to take on the trial lawyers.

That is true, but it does not make it right. Maybe somebody should take on the trial lawyers because there are a lot of estimates of how much money could be saved through meaningful medical malpractice reform. This jackpot justice system of ours that pays trial lawyers and requires physicians to pay as much as $200,000 a year in liability insurance premiums—all of which, of course, have to be passed on to the cost of our care, and perhaps even worse than that, practice what is called defensive medicine—raises the cost of our health care. Defensive medicine is having all kinds of tests performed and maybe putting someone in the hospital an extra day or two all in order to protect from a liability claim that their doctor did not do everything he could to take care of this poor patient and, as a result, the patient got sicker and something bad happened.

There are a lot of estimates. First, one estimate is from a study that says 10 cents on every dollar spent on health care is paid in insurance premiums by physicians. Obviously, some of that will still have to be paid with medical malpractice reform, but it could be reduced as has been the experience in the State of Arizona and the State of Texas, which is the reason Senator CORNYN from Texas and I have introduced legislation that will provide modest reforms to the tort system by putting some modest caps on noneconomic damages awards and providing that expert witnesses who testify have to be really expert witnesses in the area of the alleged malpractice.

These two things have saved enormous amounts of money. In Arizona, we don't even have caps on damages, but the Requirement that expert witnesses really be expert has ended up saving millions of dollars and reducing the malpractice premiums for physicians in the State of Arizona.

This is a reform we could accomplish on a bipartisan basis that not only would not cost anything, it would actually reap financial benefits. The Congressional Budget Office says just the savings to the U.S. Government—because we provide care under Medicaid, Medicare, and to our veterans—would save $54 billion. There are a lot of estimates that are higher than that. There is one estimate that is over $100 billion a year.

The Director of CBO acknowledged to people of the Finance Committee when we asked that $54 billion savings would actually be approximately doubled if we take into account the private sector as well. In other words, not only the Federal Government would save that much money, which pays about half of all health care dollars in the United States, the private sector, which pays the other half, could save a like amount of money.

These constituents wanted to know why doesn't anybody ever talk about it. I had to tell them we are talking about it. It is just that nobody is listening.

That kind of brings up the last point I want to pass on. After meeting with these three different groups in Phoenix and talking with people elsewhere I went over the weekend, it is pretty clear to me people are becoming very frustrated with their government, and this is not good. They don't think their government is listening to them. We are elected to be their representatives, to bring their ideas to Washington. Since they can't all study up on the issues as thoroughly as we are supposed to do, they trust us to not just to do what they want, not what they say, but to use our best judgment. But they do want us to listen to what they are saying and translate that into action.

What I hear them saying and what public opinion polls verify is they are very worried about the breadth and the depth of this proposed health care reform. They say it costs too much money; it is going to get us in debt; it will raise taxes which are going to be passed through to them; it is going to raise insurance premiums; and it is going to involve a massive government intrusion into what is primarily a private matter between them and their physician, with their insurance company added into the mix. They see this along the same lines as the government takeover of banks and insurance companies and car companies and everything else, and they don't like it.

One of the reasons they don't like it is because they see their own health care being delayed or denied as a result. They appreciate the fact that if the government gets so involved that it can begin to tell insurance companies what they can pay for and tell doctors what they can do for patients, that the next thing that will happen is their care will be delayed and denied and ultimately rationed.

I read a chapter in a book by our former colleague, former majority leader of the Senate, Dr. Bill Frist, a renowned heart surgeon. I talked with former Senator Frist about it last week. He actually served for about a year in England under their health system. He makes the point in his book that there are some good things about their health system. He said the bad thing is that if someone has a serious condition, unless they are at the top of the list, they run the risk of never having their serious condition dealt with.

He gave an example of a list of 100 patients who needed heart surgery. He said they would do two a day and gradually work down the list. He said what he found was that after a few weeks, peoples' names were being taken off the list. They didn't need the surgery anymore because they had died. He said that would never happen in America. He said if we have 100 people who need heart surgery in America, we would figure out a way to get that heart surgery for them right away, and we wouldn't do two a day until we ran out of time and they ran out of life. He said that is really the difference in a system in which we are controlled by the amount of money the government chooses to put into the system every day versus the kind of system we have that takes care of people and worries about the cost later. That is why it is possible for us to say that even people without insurance get cared for. No one in this country should die because they don't have insurance because we will take care of them.

Obviously, having insurance makes the delivery of care easier, more timely, and much more cost-effective, which is why at the end of the day we want to see that everybody is insured.

The bottom line is that we do not need to throw out the baby with the bathwater, get rid of the system we have that currently takes care of most people very well in order to insure that last group of folks who don't have insurance. We can provide a voucher or subsidy to them and get them coverage.

The other thing we have to do is help to bring down the costs. Republicans have offered numerous solutions on how to do that without having the government take over the system. I mentioned one: Medical malpractice reform. It does not cost a dime, it will save billions of dollars, and it is good policy besides. So why don't we do it? Because there is a vested special interest that does not want it done. It will take money out of their pockets. That is wrong.

My question to all of my colleagues is, When are we going to stand up to the special interests? Everybody likes to whack at the insurance companies. How about taking a good hard look at the trial lawyers? And, by the way, while we are talking about insurance companies, Republicans offered several ideas on how to add more competition for the insurance companies so in those situations where they have it good, if we provide for certain reforms that we have offered, such as association health plans, small business plans, more flexible HSAs, interstate sales of insurance, all these things would provide more competition for the insurance companies and force them to lower their rates. This would make health care more affordable because it would help small businesses in providing health care for their employees.

All these things came up during these meetings. As I said, I promised my constituents I would be sure to pass their ideas on to my colleagues, and I make these comments in that spirit, hoping that we will listen to our constituents not just in Arizona but in South Dakota and everywhere else around the country. And as a result of listening to a bunch of pretty commonsense folks, perhaps we will make wiser decisions here than we otherwise would have.

I see my colleague from South Dakota is here. He had some very erudite comments to make on one of the television shows on Sunday, and I am happy to yield the floor for Senator THUNE.

The ACTING PRESIDENT pro tempore. The Senator from South Dakota.

Mr. THUNE. Mr. President, I thank my colleague for yielding the floor, and I appreciate listening to his observations about the current state of the health care debate.

Mr. President, I ask unanimous consent that I be allowed to speak for up to 20 minutes.

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

Mr. THUNE. Mr. President, as my friend from Arizona noted, there are many things about the current debate that I think raise questions with the American people. He was discussing what he had heard back in his State of Arizona regarding the current debate that is before the Congress and the concerns people have, the anxiety, the frustration, and, frankly, the fear that I think a lot of Americans have about what happens and what the ultimate result may be. For instance, will this health care reform effort lead to higher costs for them? Will it lead to questions about whether they will be able to retain that fundamental, essential relationship between the patient and the doctor?

Those are, I think, very valid questions. Frankly, we don't have answers to them because, one, we don't have a bill. We haven't seen a bill. That bill is being written, we are told, in the majority leader's office. There will be a handful of people in that room. There will not be input from our side, let alone from many Democrats in the Senate. It is going to be basically cranked out and at some point we will have a bill that will be put on the floor before the entire Senate. Having said that, it is interesting to me that this week we are going to have a vote in the Senate on an issue which, frankly, is very much a part of the debate over

health care reform and yet that vote is being separated out. I think there is a reason for that, which I will come back to in a moment.

I think it is important and telling that the first vote on health care reform here in the Senate is going to be to add a quarter of a trillion dollars to the Federal debt. That is right, $250 billion—or $247 billion, to be precise—is going to be added to the Federal debt because what the majority leader has decided to do is to bring legislation to the floor this week that would address the physician reimbursement issue. We all believe that needs to be addressed. There is no one on our side of the aisle who doesn't believe we need to address the challenge that we will face in January of this coming year. Physicians across this country, if we don't take steps, are going to be subjected to a 21½ percent pay cut. That is not something anybody I know of in this Chamber is willing to abide.

But we have a fundamental difference about whether that ought to be addressed in a way that is paid for, that actually doesn't borrow $250 billion from future generations. The reason I say it should have been in the health care reform bill, but wasn't, is because it is a part of that debate. In fact, the House of Representatives included the physician reimbursement issue in their version of health care reform and put it out of balance, but at least they were honest. They dealt with it in the context of health care reform, because it is fundamental to addressing the health care issues we have in this country. The reason I think it was left out of the Finance Committee bill, the Baucus bill, is because they knew if they put that in the bill, it would put their bill out of balance, and we had the big proclamation that had come out about how this is deficit neutral, that it is going to add $81 billion in surplus, that it is actually going to save money in the long run.

Obviously, if you back out $250 billion, you can make your books balance in the near term. But what you are doing is adding a quarter of a trillion dollars to the debt, which this year was $1.4 trillion—three times what we have ever seen here in the last 40 years or so. The last time we have seen debt of this magnitude in terms of a percentage of our gross domestic product was right after World War II. But the debt this year is three times what we have seen in recent history—at least in this last decade.

I think the first point I would make is that the first vote out of the gate on health care reform should not be to add a quarter of a trillion dollars to the Federal debt and to pile this burden on future generations of Americans. In fact, there is a bumper sticker going around right now, which I think is perhaps pretty descriptive of what is happening in Washington, and it says something to the effect: ''Don't tell those people out in Washington, DC what comes after a trillion dollars.'' I think the American people are sitting out there wondering, when we talk about billions and billions and billions, and now we are talking trillions and trillions and trillions, what comes after that? And yet we continue to spend and borrow as if there is no tomorrow. I think the American people are picking up on that, and obviously they want to see a government that lives within its means just as they have to every single day in their personal lives, in their businesses, and most people who have to live within balanced budgets.

It is a lesson I think Washington could learn. It is essential that we don't continue to pile this burden of debt on future generations of Americans. The deficit last year was $1.4 trillion. It is estimated if we stay on the current trajectory that we will double the Federal debt in 5 years, triple it in 10 years, and at the end of the 10-year period, the average part that each household in this country will own of that entire Federal debt obligation is $188,000. So if you are a family in America today or say you are a young couple who has just gotten married, and looking at your life ahead of you and planning for your future, you are going to get a wedding gift from the Federal Government—a big old IOU for $188,000. That will be everyone's share of the Federal debt.

What we do here with the first vote out of the gate on health care reform is add a quarter of a trillion dollars to that Federal debt. A quarter of a trillion dollars used to be a lot of money in this town. When you start talking about $1.4 trillion deficits, maybe it doesn't seem like that anymore. I think that is why the American people are asking, and probably fairly so, what comes after a trillion dollars. When you add a quarter of a trillion dollars to the debt, the total interest payment on that amount over the 10-year period, if you can believe this, is $136 billion. So we are adding $136 billion in additional interest payments that we are going to have to make over the course of the next 10 years by borrowing an additional quarter of a trillion dollars to address the physician reimbursement issue.

I say all that because I think it bears on the bigger question of health care reform and the fact that right now we have competing bills: One in the House, called the tricommittee bill, if you will, which does spend, over a 10-year period, about $2.4 trillion; the Senate HELP Committee bill, which over a 10-year period spends $2.2 trillion; and the Senate Finance Committee bill, which over a 10-year time period spends $1.8 trillion—until now. When we add in this $250 billion for physician reimbursements, that now pushes the number on that particular bill up to about $2 trillion as well.

So what we have is a whole new expansion, a whole bunch of new spending on health care by the taxpayers in this country. Obviously, it has to be paid for somehow. Most of it is paid for by cuts to Medicare reimbursements that providers in this country would receive, paid for in the form of higher taxes that would be borne by small businesses, by individuals, and would ultimately lead to the final outcome of this big debate, which is higher premiums. The whole purpose of this was to reduce the cost of health care for people in this country by reducing and driving down what they paid for health insurance. But as has been pointed out, I think over and over now in response to questions posed by members of the Senate Finance Committee in answers from the CBO Director, these tax increases—roughly dollar for dollar—will be passed on in the form of higher taxes. In fact, some of the taxes in the House bill hit squarely at small businesses and hit squarely at individuals. The CBO and the Joint Tax Committee, which looked at the Finance Committee bill, concluded that 90 percent—87 percent, I should say, as far as the Joint Tax Committee and 89 percent was the CBO estimate—of the tax burden would fall on taxpayers—on wage earners—making less than $250,000 a year. In fact, the Joint Tax Committee went so far as to say a little over 50 percent of that tax burden would fall on wage earners making less than $100,000 a year.

So the tax burden is going to be borne by people who were promised they wouldn't pay higher taxes in the health care reform proposals, and it was stated by the President and others that we wouldn't tax people who make less than $250,000 a year. That is clearly not the case. There is a 5.4 percent surcharge on high-income earners in the House bill which would be borne largely by small businesses, many of whom file, because of the way they are organized, on their individual tax returns. So you are going to have higher taxes on small businesses, higher taxes on middle-class Americans, and this explosion and expansion of Federal Government here in Washington to the tune of $2 trillion.

You would hope then that you would see that would have some positive impact on health insurance premiums. The reality is, as I said earlier, it does not. I think as the debate broadens and we become engaged on health care reform, the American people are going to come to that conclusion, which is why I think they are very concerned about what is happening here in Washington.

The other point I will make is that one of the objectives of health care reform—in fact, to me, health care reform ought to be about driving health care costs down, not increasing them, which is what all these bills do—was that it was designed to cover people who aren't currently covered, to provide access to more Americans. What we are seeing now with all these various bills is there are lots of people who get left out. Under what they call the House bill—the tricommittee bill—17 million Americans still would not have

health insurance. Under the Senate HELP Committee bill, that number is much higher. It is 34 million who would still not be covered. But there is an assumption there, although it wasn't included in the bill, that Medicaid would be expanded. That would cover more people. So that number may be overstated. But the Senate Finance Committee assumes 25 million people will be without health insurance.

So you will have higher taxes, a tremendous amount of higher spending—up to about $2 trillion under any of these bills—and an expansion of government here in Washington, DC, cuts to Medicare reimbursements—to seniors—across this country, and all for what? Higher premiums for most Americans, for people who currently have insurance, to hopefully cover some Americans. When you are spending $2 trillion, there ought to be some advantage to that, but clearly a lot of Americans are still going to be without health insurance when this is all said and done.

I am concerned. I think a lot of our colleagues here in the Senate—and not just on our side of the aisle, but I think a number on the other side too—have expressed concerns about starting the debate a quarter of a trillion dollars in the hole by putting a bill on the floor that is going to spend a quarter of a trillion dollars—$250 billion—over the next 10 years that is not paid for. That puts any bill that is considered later completely out of balance, and it is a gimmick that is designed to allow the President and the Democratic majority to say our health care reform bill is deficit neutral. Well, sure, if you take the $250 billion and back it out, it is easy to say it is deficit neutral, when in fact now it is going to be $200 billion. They have about an $80 billion overage on the bill in the Finance Committee, but it is still going to be $200 billion out of balance when you do this, again, to be financed with more debt and more borrowing, which is exactly what I think we want to avoid, and particularly when you are running deficits as far the eye can see.

This last year, about 43 cents out of every dollar that was spent here at the Federal level—in Washington, DC—was borrowed. There isn't anyplace in America where you can function like that and still be in business. If you are a person doing that in your personal household finances, you would be forced into bankruptcy. If you were a small business, you would be forced into bankruptcy. Frankly, were it not for the fact that other countries around the world are financing America's debt, we would be in bankruptcy. Because you can't borrow 43 cents of everything you spend, as we are doing here in Washington, DC. In fact, to put it in perspective—and a lot of Americans understand this—if you are a family with an annual income of $62,000, it would be the equivalent of spending $108,000. That is what we are doing here in Washington, DC. Of all the money we spend in a given year, 43 percent of that is borrowed. We cannot continue to sustain that.

I hope that before this bill comes to the floor, we can reach an agreement about amendments that might be offered. I would say our side, the Republican side, has amendments it would like to offer to this bill that would help pay for it, help reduce the amount or perhaps entirely reduce the amount that would be borrowed in order to finance the physician reimbursement fix, on which we all agree. As I said, there is not anybody on this side who does not agree that needs to be done. In fact, Senator CORNYN offered an amendment to the bill that would provide a 2-year fix, a 2-year solution to the problem for physician reimbursement. It was voted down. It was defeated, that amendment, in the Senate Finance Committee.

We are looking. We are proactive. We have to address this issue. This issue was created by the Balanced Budget Act back in 1987. I was a Member of the House of Representatives at the time. I voted for that balanced budget agreement, but it included what was called a sustainable growth rate formula by which physicians are reimbursed. As I said earlier, in January of this year, based upon that formula, physicians would receive a 21.5-percent reduction in their fees, in their reimbursements.

Everybody here—I should not say everybody. I can't speak for everybody. But I think most Senators on both sides of the aisle acknowledge that issue has to be addressed. We need to fix that, but we have to do it in a way that is fiscally responsible. We want an opportunity to offer amendments that would allow us to do that.

As of last week, that request was being rejected. There was going to be a cloture vote today, which I understand now has been vitiated, which means perhaps the leaders are working together on an agreement that would allow Senators on both sides to offer amendments to this legislation that would help pay for it.

I think it is telling that there are Democrats who are uncomfortable with the idea of adding $¼ trillion to the Federal debt with the very first vote we will cast on health care in the Senate Chamber.

I hope we can reach an agreement. I hope the leaders will be able to do that and this will be an open process, that we debate, and there will not be any mad rush to try to cut off debate. Rather, Senators on our side would have an opportunity to fix the issue that is going to put a lot of physicians in a very uncomfortable position if we do not address it but do it in a way that also is fair to the American taxpayer and make sure we, as a nation, are honoring the responsibility we have, not just to fix this issue for today but to provide a better and brighter and more secure future for future generations of Americans. It is a future which, I would add, is very much in jeopardy and in peril if we continue to spend and borrow and tax at the rate that is contemplated in the health care reform bill but, more important, with the very first vote on that health care proposal, which is to add $250 billion to the Federal debt.

I yield the floor.

I suggest the absence of a quorum.

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

The bill clerk proceeded to call the roll.

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

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

HEALTH CARE REFORM

Mr. CASEY. Mr. President, I rise to talk about health care in three ways, three different subjects but all vitally important to making sure we get the job done in the next couple weeks. As many Americans know, in the Senate right now, we have the HELP Committee bill that passed in July and the recent passage of the Finance Committee bill coming together in a merger process which is days away from completion or certainly in the near future. As that process unfolds, there are parts of our bill, meaning the HELP Committee bill, that I hope remain intact or at least, in large measure, are left as part of the final Senate bill.

One part is on the issue of children's health insurance. We had an important debate about this program, which was authorized in 2009, so that within the next several years, within the next 4 years, maybe by the end of 4 years, we will have as many as 14 million children across America covered by that program, a tremendous advancement from where we were even 10 years ago. It has shown results in a lot of places. It is a well-tested program.

One of the more recent debates, within the Finance Committee, was whether children in CHIP, whether that program itself would be stand-alone—as I believe and as I am glad the Finance Committee agreed with me and with others—or whether it would be folded into the exchange. They didn't do that in the Finance Committee. I am glad they did not.

In this instance, we have a program which started in States such as Pennsylvania back in the early 1990s and then became a national program in the mid-1990s, about 1997. What we have seen in Pennsylvania are tremendous results. I ask unanimous consent to have printed in the RECORD a one-page survey by the Pennsylvania Insurance Department from 2008 about uninsured numbers, ages zero to 18 and then 19 to 64.

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

Estimated Number of Pennsylvania Children and Adults Who Lack Health Insurance by County [1]

	Age 0 to 18				Age 19 to 64			
County	Uninsured	Insured	Total	% Uninsured	Uninsured	Insured	Total	% Uninsured
Adams	2,331	21,766	24,097	10%	9,558	53,515	63,073	15%
Allegheny	5,883	274,523	280,406	2%	69,529	665,405	734,934	9%
Armstrong	1,590	13,415	15,005	11%	4,330	38,093	42,423	10%
Beaver	2,143	36,695	38,838	6%	12,914	92,130	105,044	12%
Bedford	1,771	9,336	11,107	16%	6,047	24,200	30,247	20%
Berks	3,770	96,735	100,505	4%	27,803	216,690	244,493	11%
Blair	572	28,417	28,989	2%	8,212	67,702	75,914	11%
Bradford	983	14,062	15,045	7%	4,740	32,474	37,214	13%
Bucks	4,575	147,546	152,121	3%	34,950	353,694	388,644	9%
Butler	898	43,541	44,439	2%	9,864	102,590	112,454	9%
Cambria	276	31,312	31,588	1%	11,095	76,889	87,984	13%
Cameron	45	1,168	1,213	4%	372	2,845	3,217	12%
Carbon	462	12,681	13,143	4%	5,534	33,222	38,756	14%
Centre	344	31,119	31,463	1%	11,730	82,134	93,864	12%
Chester	1,440	122,984	124,424	1%	24,300	275,731	300,031	8%
Clarion	544	8,518	9,062	6%	3,777	20,901	24,678	15%
Clearfield	759	16,863	17,622	4%	7,502	42,994	50,496	15%
Clinton	160	8,490	8,650	2%	2,538	19,831	22,369	11%
Columbia	1,036	13,555	14,591	7%	5,966	34,076	40,042	15%
Crawford	616	21,033	21,649	3%	8,190	45,437	53,627	15%
Cumberland	4,188	46,941	51,129	8%	16,021	124,999	141,020	11%
Dauphin	3,882	58,147	62,029	6%	14,038	143,028	157,066	9%
Delaware	9,362	136,524	145,886	6%	36,927	294,072	330,999	11%
Elk [2]	440	7,340	7,340	6%	1,371	18,590	19,961	7%
Erie	1,539	68,984	70,523	2%	16,250	153,179	169,429	10%
Fayette	1,569	30,051	31,620	5%	15,348	73,428	88,776	17%
Forest	42	1,137	1,179	4%	649	3,567	4,216	15%
Franklin	2,225	30,731	32,956	7%	13,814	70,357	84,171	16%
Fulton	134	3,272	3,406	4%	1,131	7,899	9,030	13%
Greene	333	8,393	8,726	4%	3,667	22,128	25,795	14%
Huntingdon	642	9,118	9,760	7%	4,043	24,908	28,951	14%
Indiana	1,261	18,459	19,720	6%	6,284	48,583	54,867	11%
Jefferson	814	9,387	10,201	8%	4,031	23,322	27,353	15%
Juniata	219	5,438	5,657	4%	1,785	12,239	14,024	13%
Lackawanna	3,267	43,955	47,222	7%	19,025	105,589	124,614	15%
Lancaster	16,301	114,518	130,819	12%	25,582	267,379	292,961	9%
Lawrence	1,011	19,973	20,984	5%	7,713	46,223	53,936	14%
Lebanon	1,290	28,407	29,697	4%	8,554	67,877	76,431	11%
Lehigh	2,745	79,598	82,343	3%	28,697	174,562	203,259	14%
Luzerne	2,129	65,441	67,570	3%	14,100	174,269	188,369	7%
Lycoming	1,402	25,987	27,389	5%	9,719	61,528	71,247	14%
McKean	453	9,696	10,149	4%	5,250	21,313	26,563	20%
Mercer	1,205	26,519	27,724	4%	10,083	59,853	69,936	14%
Mifflin	542	10,402	10,944	5%	3,116	23,793	26,909	12%
Monroe	795	40,919	41,714	2%	16,895	88,087	104,982	16%
Montgomery	7,379	182,900	190,279	4%	34,577	437,010	471,587	7%
Montour	106	4,114	4,220	3%	1,106	9,385	10,491	11%
Northampton	890	67,579	68,469	1%	19,189	161,434	180,623	11%
Northumberland	411	18,772	19,183	2%	5,548	49,900	55,448	10%
Perry	971	9,785	10,756	9%	4,030	24,681	28,711	14%
Philadelphia	26,012	373,302	399,314	7%	131,608	728,700	860,308	15%
Pike	1,386	11,986	13,372	10%	6,267	30,232	36,499	17%
Potter	191	4,096	4,287	4%	1,779	8,474	10,253	17%
Schuylkill	197	29,556	29,753	1%	9,371	81,244	90,615	10%
Snyder	699	8,697	9,396	7%	2,181	21,297	23,478	9%
Somerset	688	15,474	16,162	4%	6,613	41,350	47,963	14%
Sullivan	46	1,300	1,346	3%	482	2,992	3,474	14%
Susquehanna	982	8,730	9,712	10%	4,278	21,287	25,565	17%
Tioga	898	8,563	9,461	9%	3,159	21,517	24,676	13%
Union	1,264	7,975	9,239	14%	6,601	21,497	28,098	23%
Venango	629	12,068	12,697	5%	5,038	28,339	33,377	15%
Warren	321	8,978	9,299	3%	2,963	22,172	25,135	12%
Washington	1,416	43,772	45,188	3%	17,036	108,985	126,021	14%
Wayne	301	10,758	11,059	3%	5,271	25,529	30,800	17%
Westmoreland	1,827	75,593	77,420	2%	21,682	201,168	222,850	10%
Wyoming	230	6,522	6,752	3%	1,889	15,452	17,341	11%
York	4,166	94,872	99,038	4%	34,215	226,913	261,128	13%
Total	138,558	2,858,488	2,997,046	5%	877,927	6,680,883	7,558,810	12%

1. Figures derived from the 2008 Health Insurance Survey conducted by Market Decisions LLC for the Pennsylvania Insurance Department (PID). All numbers and percentages are estimates and have margins of error that must be considered in any assessments or comparisons. (See the section on survey methodology in the survey, available on the PID Web site). This chart does not reflect what portion of the uninsured may be eligible or may qualify for CHIP, adultBasic, Medicaid, or any other government program. 2. Due to the small number of uninsured children found in the sample in Elk county, the number was estimated based on the results in adjacent counties.

Mr. CASEY. What this chart shows is when we compare individuals who happen to be zero to 18 in age versus 19 to 64, we find that in Pennsylvania, across the 67 counties, we have an uninsured rate of 5 percent among children. So ages zero to 18, it is 5 percent uninsured. It is still too high—we want to bring that down to zero—but much lower than it had been. But among the age category 19 to 64, meaning everyone above the age of 18 prior to the time they have an opportunity to receive Medicare, 12 percent are uninsured in Pennsylvania. I doubt that is much different across the country.

One of the lessons from that is that when we take concerted action to focus, whether it is public resources or private resources but of a strategy for health care, we can bring the numbers down dramatically. So children's health insurance in Pennsylvania is in much better shape than it was 10 or 15 and certainly 20 or 25 years ago. But we haven't, as a country, begun to focus on that age category 19 to 64. If it is 12 percent in Pennsylvania, it is probably similar across the country because there has been no strategy for people in that age category comprising our workforce.

We have to bear that in mind. When we have one category with an uninsured rate of 5 percent versus another that is more than double that at 12 percent, we have to continue to focus strategies in the debate on that age category. In this process of coming to a bill, I believe there are several policies and several strategies that will get us to the point where the rate for ages 19 to 64 will come down as well. As many Americans know, the Affordable Health Choices Act, the bill from the HELP Committee, has as its goal and is premised upon the idea of covering as many as 97 percent of the American people. We finally have a strategy for every age group in addition to what we have tried to do for children and what we have done to help older citizens, over more than 40 years now, over the age of 65 or 65 and up.

One of the parts of the HELP Committee bill which does not get a lot of attention is a part of the bill which is set forth in sections 3201 to 3210. It starts on about page 228 of the HELP Committee bill. I know these bills are big, well more than 800 pages, but this section on the Community Living Assistance Services and Supports Act, the so-called CLASS Act, is a breakthrough—I think to be understated—because what it does is provide individual Americans who have functional limitations to be able to continue working but also to provide some of the help that goes into providing them the wherewithal to continue working.

Here is what the fundamental purpose is. I am reading from the summary: The fundamental purpose of the bill ''is to establish a national voluntary''—voluntary—''insurance program for purchasing community living assistance services and supports in order to provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence''—probably the most important word in that paragraph—''and live in the community through a new financing strategy for community living assistance services and supports,'' and ''establish[ing] an infrastructure that will help address the Nation's community living assistance services and supports needs, and alleviate burdens on family caregivers.''

What we have now, unfortunately, in many places is two or three major problems. The individuals themselves are not able to work sometimes; they have an inability to work because of limitations, and they are not able to pay for the kind of care they need. That is the main problem.

The second problem is, in many families, caregivers try to make up for that. If the family member with limitations cannot pay for services, family members provide the kind of services they would hope to get from some other person or entity.

What we are doing here is relieving a burden on individuals so they can be fully functional and independent because of the support and help they get, such as someone coming into their home in the morning to help them get off to work and to be able to meet them at the end of the day and help them with so-called activities of family living, things we all take for granted in our daily lives: everything from feeding and bathing and other fundamental things that all of us have to do every day. With a little bit of help from someone, many Americans can lead a life of employment, a life of dignity, and a life of contribution to our economy.

It also gives some real help to family members. So we will talk more about the details of how this works. I should mention the person who was the driving force on this legislation—and he and his staff worked on this for years—was the late Senator Kennedy. He spent many years developing this program, developing the CLASS Act, and making sure it was part of our bill. That is why we wanted to make sure it was part of the Affordable Health Choices Act, and it should be part of the final health care legislation we enact here in the Senate. If we are going to do the right thing, it will be in the bill. I think most people here want to do the right thing as it relates to people with functional limitations who can contribute more to their workplace and contribute more to our economy.

Senator Kennedy's work was focused not just on providing a program to give people that opportunity, his focus was also: How can we do it in a way that is fiscally responsible? Well, this program provides not just a lot of help for people with limitations and their families, but it also does not cost the Federal Government in the process because people will be paying in overtime and then have the opportunity to use those resources when they need them.

Let me finally move to another area in the remaining time I have. In addition to the importance of preserving the Children's Health Insurance Program the way it is right now—which I think was a great advancement in the Finance Committee—in addition to enacting legislation which will have the CLASS Act as part of it, the third thing I am going to mention today is an issue that has received a lot of attention, but sometimes we do not highlight some of the elements that are very important to the American people. I speak of the so-called public option, which in our Senate health care bill, the HELP Committee bill, is entitled the ''Community Health Insurance Option.''

One of the most important parts of the bill—in fact, I think the first word in the section is the word ''voluntary.'' When I was going across Pennsylvania talking to people about our health care bill—and our bill passed in July, so when I was on the road in August, we had a chance to talk about a bill, not just a concept but a bill we had already passed out of committee—some people who were opposed to the public option would ask a question or make a statement, and often they would say to me: Well, I don't want to be forced into some government program and lose my ability to choose or lose some of the rights I have now.

I would point to the Community Health Insurance Option section of the bill and say: The first word is ''voluntary.'' There is no requirement here. I think that mythology kind of got ahead of the truth. It is voluntary; that is, voluntary as it relates to an individual but also voluntary as it relates to a provider.

Second, as to the benefit package, as we wrote it in our bill, in the HELP Committee, it would meet the so-called gateway. In our bill we call it a ''gateway.'' In the other bills, they call it an ''exchange.'' But it meets the gateway standard by offering coverage that has an essential benefit package, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, preventive and wellness services, and pediatric services. States can offer additional benefits beyond that essential benefit package with any cost of such additional benefits being assumed by the State. So that is what the public option in our bill, the Community Health Insurance Option, would offer as a benefit package.

The premium rates will be set by the Secretary of Health and Human Services at an amount sufficient to cover expected local costs—local costs. So you are going to have a lot of impact and relevance as to what is happening in the local community. And also—this is very important—the Community Health Insurance Option has to meet

solvency standards. It cannot just operate and not worry about standards that involve solvency. If there are States that have higher levels or higher requirements as to solvency, the public option would have to meet that.

The reimbursement rates will be negotiated by the Secretary and shall not be higher than the average of all local—local—gateway reimbursement rates.

I mentioned the importance of solvency as a requirement.

Startup funds will be provided by the Treasury to cover costs of initial operations and cover payments for the first 90 days of the plan's operation. But then that public entity, which is State based, would have to pay the money back over time. I think that is critically important to point out.

Finally, State-based advisory councils will provide recommendations to the Secretary on operations and policies regarding the Community Health Insurance Option, to take advantage of local innovative efforts and meet local concerns. So this is not some entity that is going to operate in Washington. It is an entity that will have not just public input and local input and local relevance but actually will take advantage of local innovative efforts that we see all across the country. I know in Pennsylvania there are hospitals or hospital systems or communities that do things a different way and are very successful, and we have to be giving them the opportunity to have that kind of flexibility.

I believe it is the right thing to do to have as part of the final bill a public option. I believe our bill we passed out of committee is the right way to do it. Others might have another version of it. But I believe the Community Health Insurance Option is a voluntary, focused way to make sure we are injecting real competition and thereby lowering costs but also enhancing choice.

One thing we do not want to do at the end of this road is limit choices people have. A lot of people will stay with their private insurance policy or their private plan. They will want to stay there. But others may say: I am in such a predicament or I am in such a cost situation that I need to choose a public option.

Finally, Mr. President—I will wrap up with this—I believe this debate has been critically important to the American people, even the debates that get a little heated. It is very important we get this right. It is very important we have spent the time we have spent over these many weeks and months. But we are reaching the point now where we are down to weeks, thank goodness, not months.

I believe we can get this right, we can put in place strategies to give people peace of mind, so when they go to work in the morning, they do not have to worry, as they do, about health care—the cost of it, the burden of it, being denied coverage because of a preexisting condition or having a child denied coverage because of that or a loved one. I believe we can also begin to wrestle the costs to the ground and not have them spiraling upward, as they have been doing for 10 or 15 or more years. I also believe we can enhance choice and quality.

Even with all the debates we are having, all the disagreements we sometimes have here in Washington, there is a lot of consensus about the need to pass a bill, about the need to enhance prevention efforts and quality efforts. I believe we can get there. But we will continue to highlight some major aspects of the bill, and we are going to continue to fight hard for these fundamental priorities of health insurance reform.

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

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

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

The ACTING PRESIDENT pro tempore. There is no divided time at this point. Morning business goes until 4:30 p.m.

Mr. ALEXANDER. Mr. President, I ask unanimous consent to speak in morning business.

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

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, after a lot of serious debate and discussion, we apparently are about to come to the point where we have our first vote on health care reform.

What is it the Democrats—those on the other side—propose we do? Add one-quarter of a trillion dollars to the national debt. I thought this debate was supposed to be about reducing costs—reducing costs to the government and reducing costs to individuals across this country who cannot afford to pay for health care insurance. And then, as we find ways to reduce the costs of what we are doing, we can begin to expand health care coverage to the Americans who do not have insurance. But it is as big a problem—or bigger—today that those who do have health care insurance—and that is about 250 million of us out of 300 million—that many Americans cannot afford their health care.

So our focus is, I thought, on cost. How do we reduce costs to the government and costs to the American people? What we see is that the very first vote on health care reform will be on a proposal to increase the debt by $247 billion over 10 years in order to pay for Medicare doctors reimbursements. This is not the insurance companies talking. This is not the Republicans talking. This is not one news commentator talking. This is the proposal by the Democratic side, that the first vote will be to increase the debt by a quarter of a trillion dollars.

I wish to talk for a few minutes about this bill as we see it. Here we are supposed to be having legislation to reduce the costs to the government, and we apparently are going to, as the first step in the wrong direction, add a quarter of a trillion dollars to the government. The second thing we are trying to do is to reduce your costs—the costs that each of us pays for our health care insurance. The outlines of the bill we see coming through the Congress would actually increase premiums.

I would ask the American people and ask my colleagues: If our goal is to reduce costs—and we are adding to the debt and increasing premiums instead of reducing premiums and reducing the debt—why are we doing this?

Let me start first with adding a quarter of a trillion dollars to the debt. Here is what the proposal would be. You will remember a few days ago there was a great deal of congratulations when the Finance Committee finished a lot of hard work, and they said: This is a deficit-neutral bill. It doesn't add anything to the debt. That is what the Congressional Budget Office said based on a series of assumptions. That is something to be proud of because the President himself has said he won't sign a piece of legislation that adds one dime to the debt, and then he added to that, ''and I mean it,'' like a parent who wanted to make sure he was being heard by unruly Members of Congress.

I am glad he said that. I heard him say it earlier in the year when he had a summit on the condition of the Federal budget. Democrats and Republicans—we all went down to the White House. People came in and said: If we don't do something about the increasing debt in our country, our children and grandchildren aren't going to have a country. That was not overstating it. Everyone at the President's summit agreed that the principal cause of runaway debt in America is health care. It is Medicare and Medicaid.

Just these past few days—here is the weekend newspaper in Tennessee. This is the Nashville Tennessean on Saturday: ''Deficit leaps to $1.4 trillion.'' I think most Americans—I know at least most Tennesseans—are deeply concerned about this. But lest you think a Republican Senator is exaggerating the problem, let me just read a few paragraphs from the Associated Press story:

Deficit leaps to $1.4 trillion. Economists warn of crisis if U.S. fails to act.

This is an Associated Press story.

What is $1.42 trillion? It's the federal budget deficit for 2009, more than three times the most red ink ever amassed in a single year.

It's more than the total national debt for the first 200 years of the Republic, more than the entire economy of India, almost as much as Canada's, and more than $4,700 for every man, woman and child in the United States.

Yet the first proposal, the first vote on health care is going to be to add to that debt.

The Associated Press article continues:

As a percentage of U.S. economic output, it is the biggest deficit since World War II. And, some economists warn, unless the government makes hard decisions to cut spending or raise taxes, it could be the seeds of another economic crisis.

Yet the first vote on the health care reform bill will be to add a quarter of a trillion dollars over the next 10 years to the national debt.

Quote:

''The rudderless U.S. fiscal policy is the biggest long-term risk to the U.S. economy,'' said Kenneth Rogoff, a Harvard professor and former chief economist for the International Monetary Fund.

Quote:

''As we accumulate more and more debt, we leave ourselves very vulnerable.''

Yet the first vote that is proposed on the health care reform bill is to add a quarter of a trillion dollars to the national debt. This seems unbelievable.

I ask unanimous consent to have printed in the RECORD following my remarks the article by the Associated Press from the National Tennessean of last Saturday.

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

(See exhibit 1.)

Mr. ALEXANDER. Mr. President, the issue at hand is something with which we are all very familiar. It is called the doctors reimbursement problem. When the 40 million seniors on Medicare go to see a doctor, the doctor is paid at a rate set by the government. That rate is only about 80 percent of what the doctor would be paid if the doctor was seeing a person with private health care insurance.

There is a complicated formula in the law that says those doctor payments will go down over the next several years—by as much as 25 percent over the next 2 years. The Congressional Budget Office has estimated that over the next 10 years, just to pay physicians the same they are being paid today, which I don't think very many physicians would be happy with, will cost $247 billion more than is accounted for in the Baucus bill that came out of the Finance Committee. So they just assumed it wouldn't be paid to physicians and the doctors would be, in effect, paying for the health care bill.

Well, suddenly some people on the other side of the aisle said: Oh, we can't do that, so we will just separate it from the health care debate. Actually, I think they have done us all a favor because they have made it the first vote on the health care reform bill. So we will have a chance to vote up or down on whether we want to add a quarter of a trillion dollars to the national debt. My experience in life is that most people remember their first impression, and if their first impression of voting on the health care reform bill is that the Congress starts off by just brazenly adding a quarter of a trillion dollars to the national debt at a time when the deficit has just leaped to $1.4 trillion in 1 year, then I think the American people will have a pretty good idea of what we are about here.

I think the President doesn't—I can't imagine him wanting this, based upon his saying, ''I will not sign health care reform that adds even one dime to our deficit.'' And this is part of health care reform, make no mistake about that. This is part of the bill. It is part of the problem. We are looking at health care over the next 10 years. That is the way our budget cycles work. Everyone is scoring it or estimating its costs based upon what it costs over the next 10 years. To pay doctors 10 years from now what they are being paid today—which I doubt many doctors would be very happy with—will cost $247 billion.

So instead of saying, let's find ways to cut other programs or raise taxes, we say, let's add a quarter of a trillion dollars to the debt. Adding a quarter of a trillion dollars to the national debt as the first step in the health care reform debate is the first step in the wrong direction. Of course we need to fix the problem of doctors reimbursement. It needs to be a part of what we do this year in health care reform. But just as with other parts of health care reform, we don't add to the debt to do that. At least that is what the President has said. At least that is what Republicans have said. And at least that is what the American people are saying at a time when the debt goes up and up and up.

The next problem is that not only is the cost to the government going up and our first vote on health care reform about to be to add to the debt, the outlines of the bill we are seeing increases premiums.

Over the weekend, the President said: Well, it is those mean old insurance companies trying to mislead you.

You don't have to be an insurance company to understand that the premiums are likely to go up. In the first place, the Finance Committee reduced the penalty you pay if you don't buy insurance to a level that will cause a lot of people not to buy insurance—at least that is the estimate of many—and if younger people especially don't buy insurance, the pool of people who do buy insurance gets smaller and the people in that pool find their premiums going up.

No. 2, the bill says—the outlines of the bill; of course we don't really have a bill. We will have a bill within the next several weeks, I imagine, or maybe several days. The bill says it is going to make it more expensive for my sons—one who is 30 and one is 40—to buy insurance and closer to what it costs for me. Right now across the country, I might pay eight times as much for my insurance as younger people do, but under this law it is going to say: We don't like that big gap between younger people and older people, so it might have to be two to one or three to one. Basically, it raises the cost of insurance for young people as a way of reducing it for older people. That means the premiums of younger people will go up, and it also means they may elect to get out of the system, make the pool smaller, and as a result of that, all premiums would go up.

No. 3, there is a provision in the law that says you must buy in many cases a government-approved health care insurance. Many people choose a high-deductible insurance where you only buy insurance for the big problems you know you can't afford and you pay less for your monthly premiums that way. A government-approved insurance policy might make it not as easy for you to do that. One estimate in Tennessee is that the cost for one of these high deductible plans would go from $50 a month to $400 a month—a big increase for those who buy high-deductible insurance policies. That is the third way your premium might go up.

Then the fourth way and final way, in addition to this concept we see coming from the Finance Committee that your premiums might go up, is there are $955 billion in new taxes. They say that is if we are taking a 10-year period after the program is fully implemented. They say: Well, those are taxes on other people. But they are taxes on your insurance company, taxes on the person you buy a medical device from, taxes on other people in the health care industry. What do you suppose companies do in any area that get additional taxes? For the most part, they pass those taxes on to you.

So there have been a number of independent observers who have said that because the individual mandate has been weakened, because young people are going to have to pay more for their insurance as compared to older people, because the government-approved policy is not going to allow so many high-deductible policies that many Americans like, and because nearly $1 trillion in taxes is eventually going to be over 10 years passed on to people who buy insurance, for all of those reasons, premiums are likely to go up.

So we are about to begin the debate on this floor on health care reform. It is one we need. What Republicans believe—and I see my friend from Delaware who I gather wishes to speak, and I will wind up so he can. But here is what we should do. We need health care reform, but health care reform is first and foremost about reducing costs, first to the government and next to individuals. To re-earn the trust of the American people on this score, we should start step by step with specific proposals that reduce costs; for example, allowing small businesses to pool their resources and offer insurance to their employees. Our own committees have estimated that this could add millions of people to the insured rolls. Second, reduce junk lawsuits that drive up costs. We disagree about how much it drives up the cost of insurance, but we don't disagree that it does. Third, allow people to buy insurance across State lines. That would create more competition. Fourth, create more

health insurance exchanges so people can shop and find more different kinds of policies. Fifth, most all of us agree we need to encourage more health information technology and make health care simpler in that way. Perhaps we could even agree to change the tax incentives so that they don't all go to one group of people and are not going to lower and middle-income people.

There are four or five or six or seven ideas we could go step by step with to reduce costs. If we did that, we would be moving in the right direction. It is the wrong direction to start the health care debate with a vote that adds a quarter of a trillion dollars to the national debt at a time when we just added $1.4 trillion to the national debt in the past year. Of course we need to fix the doctors reimbursement, but it needs to be paid for by—it can't be added to the debt.

Whatever steps we take ought not just reduce the cost to the government; they need to reduce the costs to Americans, all of us who have health care insurance. Let's find ways to go step by step to reduce costs to the government and to reduce costs to premium holders and not start off by adding a quarter of a trillion dollars to the national debt.

EXHIBIT 1

[From the Tennessean]

DEFICIT LEAPS TO $1.4 TRILLION

(By Martin Crutsinger)

WASHINGTON.—What is $1.42 trillion? It's the federal budget deficit for 2009, more than three times the most red ink ever amassed in a single year.

It's more than the total national debt for the first 200 years of the republic, more than the entire economy of India, almost as much as Canada's, and more than $4,700 for every man, woman and child in the United States.

As a percentage of U.S. economic output, it's the biggest deficit since World War II.

And, some economists warn, unless the government makes hard decisions to cut spending or raise taxes, it could be the seeds of another economic crisis.

Treasury figures released Friday showed that the government spent $46.6 billion more in September than it took in, a month that normally records a surplus. That boosted the shortfall for the full fiscal year ending Sept. 30 to $1.42 trillion. The previous year's deficit was $459 billion.

''The rudderless U.S. fiscal policy is the biggest long-term risk to the U.S. economy,'' says Kenneth Rogoff, a Harvard professor and former chief economist for the International Monetary Fund. ''As we accumulate more and more debt, we leave ourselves very vulnerable.''

Forecasts of more red ink mean the federal government is heading toward spending 15 percent of its money by 2019 just to pay interest on the debt, up from 5 percent this fiscal year.

President Barack Obama has pledged to reduce the deficit once the Great Recession ends and the unemployment rate starts falling, but economists worry that the government lacks the will to make the hard political choices to get control of the imbalances.

Friday's report showed that the government paid $190 billion in interest over the last 12 months on Treasury securities sold to finance the federal debt. Experts say this tab could quadruple in a decade as the size of the government's total debt rises to $17.1 trillion by 2019.

Without significant budget cuts, that would crowd out government spending in such areas as transportation, law enforcement and education. Already, interest on the debt is the third-largest category of government spending, after the government's popular entitlement programs, including Social Security and Medicare, and the military.

As the biggest borrower in the world, the government has been the prime beneficiary of today's record low interest rates. The new budget report showed that interest payments fell by $62 billion this year even as the debt was soaring. Yields on three-month Treasury bills, sold every week by the Treasury to raise fresh cash to pay for maturing government debt, are now at 0.065 percent while six-month bills have fallen to 0.150 percent, the lowest ever in a half-century of selling these bills on a weekly basis.

The risk is that any significant increase in the rates at Treasury auctions could send the government's interest expenses soaring. That could happen several ways—higher inflation could push the Federal Reserve to increase the short-term interest rates it controls, or the dollar could slump in value, or a combination of both.

SPENDING LIKELY TO INCREASE

The Congressional Budget Office projects that the nation's debt held by investors both at home and abroad will increase by $9.1 trillion over the next decade, pushing the total to $17.1 trillion under Obama's spending plans.

The biggest factor behind this increase is the anticipated surge in government spending when the baby boomers retire and start receiving Social Security and Medicare benefits. Also contributing will be Obama's plans to extend the Bush tax cuts for everyone except the wealthy.

The $1.42 trillion deficit for 2009—which was less than the $1.75 trillion that Obama had projected in February—includes the cost of the government's financial sector bailout and the economic stimulus program passed in February. Individual and corporate income taxes dwindled as a result of the recession. Coupled with the impact of the Bush tax cuts earlier in the decade, tax revenues fell 16.6 percent, the biggest decline since 1932.

Immense as it was, many economists say the 2009 deficit was necessary to fight the financial crisis. But analysts worry about the long-term trajectory.

The administration estimates that government debt will reach 76.5 percent of gross domestic product—the value of all goods and services produced in the United States—in 2019. It stood at 41 percent of GDP last year. The record was 113 percent of GDP in 1945.

Much of that debt is in foreign hands. China holds the most—more than $800 billion. In all, investors—domestic and foreign—hold close to $8 trillion in what is called publicly held debt. There is an additional $4.4 trillion in government debt that is not held by investors but owed by the government to itself in the Social Security and other trust funds.

INFLATION IS A THREAT

The CBO's 10-year deficit projections already have raised alarms among big investors such as the Chinese. If those investors started dumping their holdings, or even buying fewer U.S. Treasurys, the dollar's value could drop. The government would have to start paying higher interest rates to try to attract investors and bolster the dollar.

A lower dollar would cause prices of imported goods to rise. Inflation would surge. And higher interest rates would force consumers and companies to pay more to borrow to buy a house or a car or expand their business.

Most economists say we have time before any crisis hits. In part, that's because the recession has erased worries about inflation for now. In its effort to stimulate the economy, the Fed cut a key interest rate to a record low last December and is expected to keep it there possibly through all of next year. Demand for loans by businesses and consumers is so weak that low rates are not seen as a recipe for inflation.

Robert Reischauer, a former head of CBO, said that in an optimum scenario, Congress will tackle the deficits next year. A package of tax increases and spending cuts could be phased in starting in 2013 and gradually grow over the next decade.

Mr. ALEXANDER. I thank the President, and I yield the floor.

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

EXTENSION OF MORNING BUSINESS

Mr. KAUFMAN. Mr. President, I ask unanimous consent that morning business be extended until 5:30.

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

IN PRAISE OF KENNETH E. CARFINE

Mr. KAUFMAN. Mr. President, I rise once again to recognize the service of one of America's great Federal employees. I feel fortunate to have a chance to stand here each week and share so many inspiring stories. Since the spring, I have recognized the contribution of public servants from a number of Departments, including Defense, Labor, Agriculture, and Justice, as well as Agencies such as NASA and CIA. Today, I will be speaking about an outstanding employee from the Department of the Treasury.

This is a time of great challenge to our economy, our markets, even the power of our currency. But the men and women of the Treasury and its various agencies and offices are working tirelessly on recovery and securing our prosperity. The impact they make through their daily work can be felt from coast to coast. Public servants at the Treasury Department serve on the front lines of job creation, public investment, and the management of tax income. They carry on the tradition of Alexander Hamilton, our first Treasury Secretary, who believed the health and prosperity of our Nation depended on the strong management and oversight of public funds. He laid the foundations of America's financial system, which the employees in the Treasury Department reinforce each day.

Kenneth Carfine has been serving the American people and the Treasury Department for 35 years.

A graduate of the University of Baltimore, Kenneth joined the Treasury Department's Financial Management Service in 1973, the same year I came to the Senate to work for then-Senator BIDEN. During his time there, Kenneth

worked in banking, cash management, payments, check claims, and government-wide accounting.

In recent years, he has worked under the Fiscal Assistant Secretary, serving as an adviser to senior department officials. His intellect and diligence have been critical as the Treasury addresses economic recovery.

Earlier this year, Kenneth helped direct the Treasury's implementation of its responsibilities under the American Recovery and Reinvestment Act. He led the development of two new departmental programs aimed at spurring economic growth. One of them helps renovate affordable housing for struggling families, and the other funds renewable energy initiatives.

Kenneth has also earned respect as a leader in cash-and-debt management infrastructure. Americans who use a national debit card to receive their Social Security benefits have him to thank for leading the implementation of this program.

His hand has helped shape how the Treasury deals with debt financing, trust fund administration, cash management, and a range of services.

Kenneth Carfine and all of the hard-working employees of the Treasury Department are leading the way toward economic recovery and sound fiscal management of the taxpayer's money. I hope my colleagues will join me in thanking them all for their service to our Nation.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. MERKLEY). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mrs. SHAHEEN). Without objection, it is so ordered.

Mr. WHITEHOUSE. Madam President, I ask unanimous consent to speak as in morning business for up to 20 minutes.

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

HEALTH CARE REFORM

Mr. WHITEHOUSE. Madam President, I have spoken many times on this floor about the urgency of the need to reform our broken health care system, to expand access to insurance, to improve below average results, and to bring down costs. In a speech to the joint session of Congress, the President eloquently described the challenge of this moment:

> I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge—in some way. . . . Our collective failure to meet this challenge—year after year, decade after decade—has led us to the breaking point.

We are at the breaking point for Nancy from Barrington, RI, a single mother and accomplished music teacher who lost her full-time job and currently teaches part time at a local university. Nancy has paid the full cost of health insurance out of pocket so her two children would not go without coverage. But now they have graduated from college, they are no longer eligible to be on her insurance policy, and they work at jobs that don't provide health care benefits. So Nancy is now thinking about selling her home, their childhood home, to prevent her family from going without health insurance. Nancy writes:

> Between the three of us, we are desperate for a workable solution to our health insurance needs. For the first time in my life I feel utterly disenfranchised by my own society.

We are at the breaking point, not just for Nancy but for so many Rhode Islanders who have shared with me their stories—stories of loss, stories of sorrow, stories of frustration, stories of personal and family disasters, in a treacherous health care system that offers all the care you need until you need it.

We are also at the breaking point nationally. Our country's economic future may well depend on the reforms and investments we now craft to control costs and wring savings from the system.

One measure of the potential savings is the recent report of President Obama's Council on Economic Advisers, comparing the share of America's gross domestic product spent on health care to the share spent by our industrialized international competitors, and evaluating the wide variation in health care expenses region to region within the United States.

The report estimates annual excess health care expenditures of about 5 percent of GDP. That translates to over $700 billion a year in excess cost. They are not alone. The New England Health Care Institute reports that as much as $850 billion in excess costs every year ''can be eliminated without reducing the quality of care.'' That is $850 billion.

Former Treasury Secretary O'Neill, the Treasury Secretary in the Bush administration, has written recently that the excess cost in our health care system is $1 trillion a year. The Lewin Group, a consulting firm that is well regarded on health care issues, has estimated that excess cost exceeds $1 trillion per year. So is it $700 billion a year? Is it $850 billion a year? Is it $1 trillion a year? Whatever it is, it is a savings target worth an enormous executive and legislative effort, particularly when the evidence is that achieving these savings will actually improve health care for the American people.

Where will these savings come from? Well, the savings await us in quality of care. For instance, the Keystone Project in Michigan reduced infections, respiratory complications, and other medical errors in some of Michigan's intensive care units between March 2004 and June 2005, a little over a year. The project saved 1,578 lives, 8,120 days that patients otherwise would have spent in the hospital but did not have to because they did not get the infections or the complications and, as a result, over 165 million health care dollars, just in Michigan, just in intensive care units, just in 1 year, and not all of the intensive care units.

In my home State, the Rhode Island Quality Institute has taken this model statewide with every hospital participating. We are already seeing hospital-acquired infections and costs declining. There is a similar opportunity in disease prevention. The Trust for America's Health found that investing $10 per person per year in programs that increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion annually within 5 years.

Out of that $16 billion in savings, Medicare would save more than $5 billion, Medicaid would save more than $1.9 billion, and private payers would save more than $9 billion. So that is quality of care and prevention.

A third area for significant efficiencies and savings is the insurance industry's contentious, inefficient billing and approval process. The battle over approvals for treatment and claims for payment creates a colossal burden on our health care system, causing perhaps 10 to 15 percent of the insurance industry's expenditures because the hospitals and the doctors and the providers have to fight back. That 10 to 15 percent of the insurance companies' expenditures casts a cost shadow over the provider community which is probably bigger than the insurance industry spends, because they are less efficient at fighting back than the insurance company is at tormenting them.

It all adds no health care value. None. It is pure administrative costs and cost shifting. Rhode Island providers have told me over and over that half of their personnel are absorbed in this battle and not providing health care. They are at the doctor's office, they work there, but they are not providing health care. They are busy fighting with the insurance company.

Even the insurance industry estimates that $30 billion per year could be saved through simplifications of the process. That relates to a fourth area, the overall inefficiency and waste that plagues the private insurance market.

While administrative costs for Medicare run about 3 to 5 percent, overhead for private insurers is an astounding 20 to 27 percent. A Commonwealth Fund report indicates that private insurer administrative costs have more than doubled in the past 6 years. From 2000 to 2006, they increased 109 percent.

The McKinsey Global Institute estimates that Americans spend roughly

$128 billion annually—$128 billion annually—on excess administrative overhead in the private health insurance market.

A fifth savings area is investments in our infrastructure of health information technology; secure electronic health records, for instance, electronic coordination between your doctor and your specialist and your pharmacy and your hospital and your laboratory. These investments promise big savings as well, $162 billion per year, according to one RAND study, and possibly twice that.

Finally, reform of how we pay for health care will yield enormous dividends. At the moment we mostly pay on a piecework basis. The more you do, the more you are paid. No surprise that we do a lot and pay a lot. Since the best care, the best quality care is so often less intrusive but better designed and better coordinated, this payment reform presents another win-win opportunity: better health care and lower cost, hand in hand.

There is a problem, though. For many of these reforms, CBO cannot fully score the savings they would yield, and thus their importance has been minimized in our debate. CBO can only estimate health care costs and savings that have historic precedent. For example, on the cost side we have the experience of Medicaid, and the Children's Health Insurance Program. So CBO can estimate how much it will cost to expand the coverage to needy families, as we importantly do in this bill.

On the savings side, however, CBO's capability is limited because there is not a lot of information to forecast from. CBO's Director has been refreshingly candid about this. In a recent letter to Senator CONRAD, he wrote the following:

> . . . changes in government policy have the potential to yield large reductions in both federal health expenditures and federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies should move, typically involving changes in the information and incentives that doctors and patients have when making decisions about health care . . . Yet, many of the specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

So to summarize: Large reductions in costs are possible. The general direction in which to move to achieve them is agreed. But experimentation and learning are necessary to get there.

Even with those analytical limitations, CBO has recognized some cost savings created by several innovative reforms in the Finance Committee's bill. For example, CBO forecasts that an independent nonpartisan commission of experts with authority to determine provider payment rates under Medicare will save the Treasury $22 billion over a 10-year period.

It also credits Medicare payment reforms that seek to prevent hospital readmissions with $2.1 billion in savings; incentives that encourage physicians to group together in cost savings organizations with $4.9 billion in savings, and payment reforms aimed at preventing health care-acquired infections with $1.5 billion in savings.

But as you have seen, in comparison to the numbers I talked about earlier, those are trivial projections, chump change against the excess cost of our health care system. Americans owe the Congressional Budget Office a particular debt of gratitude for how incredibly hard they have worked these past weeks and months. CBO performs a valuable service.

But its professional discipline requires it to score legislation basing its calculations on what it can chronicle has happened in the past. And we have not yet been where we need to go in health care reform. Moreover, getting there will require leadership, creativity, and perseverance in executive administration, with constant adjustments and improvements along the way to achieve our goal.

Those factors of executive administration are beyond the capability of CBO to predict. The distinguished Presiding Officer was the Governor of the State of New Hampshire. She knows well, having served as Governor, what a difference executive administration can make in areas where there is intelligent and sustained focus. Well, CBO cannot predict whether intelligent and sustained focus will occur, so they cannot predict the answer to that question.

Let me mention one further reform now that we are on the subject of executive administration, a final reform that can bring leadership and creativity toward achieving all of these goals in quality, in prevention, in payment reform, and in information technology. That is the reform that can bring leadership and creativity to pulling all of those reforms together, a public health insurance option, a government-run publicly handled plan that can provide affordable coverage in a market where premiums have increased 128 percent in 8 years.

A public option can bring vigorous competition to a market so monopolistic it would make Andrew Carnegie blush, will force private plans to minimize bloated administrative costs which have increased, as I said, 109 percent over those 6 years. The public option can pass along savings to consumers in the form of reduced premiums, and can end the wasteful practice of fighting with doctors and patients over reimbursement.

The public option is our best chance for executive implementation of the delivery system innovations and reforms I have described. Skillful executive administration will be required just as for every other element of reform. But public plans across the country, driven not by private motives but by the public good, set new standards of quality and efficiency in a market that has lost its way.

The point of this reform must be to turn around a health care system that is now spiraling out of control. We spend 18 percent of our GDP on health care. The next highest spending nation in the world is Switzerland at 11 percent. Even if our success is limited to shaving a few percentage points off our national expenditure on health care, that success will be worth hundreds of billions of dollars a year. Yes, there will need to be an initial investment in health care reform, but the potential savings are multiples larger.

CBO's inability to score these savings does not mean they aren't real and achievable. Given the looming threat to America's fiscal security that is now presented by our health care costs, these savings are not only real and achievable, they are essential. They are necessary. We are bound to achieving them, and we must not fail. For that reason, I call on the Obama administration to begin defining a health care savings target from delivery system reform—from health information infrastructure, from quality improvements, from illness prevention, from more transparency and less bureaucracy, from reform of what we pay for in health care and, ideally, all implemented rapidly and fairly by public plans around the country. They need to set a target.

If the administration does not set a savings target, there is no way the vast apparatus of the Federal Government will wheel adequately toward achieving this goal. If we fail to achieve those savings, all our dreams—our dreams of universal coverage, our dreams of affordability, our dreams of a public option—will crumble like castles built on sand.

Let's take the most conservative number from President Obama's own White House, $700 billion a year in annual excess cost. Let's assume the best we can do is to eliminate less than one-third of that excess cost—not all of it, not even half of it, less than one-third. Let's assume it takes a few years to meet that goal; let's say 4 years. That would still permit reform savings of $200 billion a year by 2014. By then, our annual health care expenditures will have climbed well over $3 trillion. So that $200 billion annual savings would be only one-fifteenth, about 7 percent, of the cost, then, of our bloated health care system, a system now costing twice as much as other developed nations' health care systems that cover everyone. That goal, 7 percent off a system that costs twice as much as in other nations, does not seem unreasonable.

I will ask the administration: What is your annual savings target out of that $700 billion to $1 trillion a year in excess cost? What is it, and when will you achieve it? Soon you will have a bill out of this Congress that gives you the tools to achieve these savings.

When you have that bill, I will ask for a number and a date.

I will urge the administration: Be bold. President Kennedy did not know how to get to the Moon when he promised that we would, but he knew we had the talent and the technology to do it, if we had the President's commitment behind it. Sure enough, it happened.

I would also remind the administration of this: We have to achieve these savings anyway. This is not an extra political hurdle the administration would have to clear. This is the bar we must clear if our Nation is to return to fiscal health and if our dreams of universal coverage and affordability and good public health and a humane, efficient health care system are all to be realized. Again, if we don't clear that bar, all those dreams crumble in our hands like dust.

Let's step forward now and make a commitment to some hard, firm measure of savings out of our bloated and inefficient delivery system.

I thank the Chair.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BEGICH). The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. BROWN. Mr. President, I ask unanimous consent to speak for up to 15 minutes in morning business.

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

Mr. BROWN. Mr. President, pretty much daily over the last couple of months when the Senate has been in session, I have come to the floor to share letters I have received from people in Findlay, OH—where I was today—Toledo, Sandusky, Mansfield, Lebanon, all over the State. These are letters from people who want to tell me why we need health care reform. These are letters mostly from people I have not met, people who know we need to change some things in this country.

What is interesting is that one of the common themes that run through these letters—in letter after letter after letter—is that people thought they had pretty good health insurance. They were satisfied with their health insurance. If you asked them a year or two ago: Do you have good health insurance, they would have probably said yes. But then they found they had a child who was diagnosed with a preexisting condition, so they were denied insurance, or they got sick and they went above the annual or lifetime cap on costs they did not even know was in their insurance policy, so the insurance company then rescinded them—is the term they use—there was a rescission to eliminate or take away their policy, or they were discriminated against for other reasons, or in many cases they lost their job and lost their insurance.

In case after case, these are people who are mostly middle class, people playing by the rules, paying their taxes, raising their kids, keeping their communities prosperous, and they typically have lost much of what they had.

I want to share some of these letters with my colleagues, particularly colleagues who are not so certain, colleagues who still defend the health insurance system and think we do not need significant change, so that they would maybe understand some of these problems a little better.

The first letter is from Wilkins from Youngstown, which is in northeast Ohio. He writes:

I'm an unemployed former steel worker from Youngstown. I've been struggling to afford my premiums for COBRA while on unemployment and looking for a job.

COBRA is a bit of a cruel hoax. It is a good program for people who can afford it. But COBRA is for when you lose your job that you can keep your insurance if you pay what you are already paying, plus you pay the employer's side of the insurance. That is almost impossible to do for most people who lose their job for a very long period of time. They are only eligible for COBRA for up to 18 months anyway. He writes:

Due to a pre-existing condition of high blood pressure, I had no choice but to continue my coverage under COBRA.

If he had a break in his health care, if he canceled his health insurance and tried to get other less expensive insurance, he would have been denied coverage because of his preexisting condition. He writes:

I'm 59 years old and have been working temporary jobs just to get by, but none offers health insurance. I barely make enough to afford my blood pressure medication.

I've depleted my savings while watching my unemployment insurance run out.

That is something else that this Chamber must consider. I just saw Senator SHAHEEN from New Hampshire a moment ago. She has helped lead the fight on extending unemployment benefits for people whose insurance has run out, something, unfortunately, day after day we have tried to do here, and a Republican Senator has stood up and objected and we have not been able to push that through yet. Unemployment insurance makes so much sense with so many people—from Dayton to Springfield to Chillicothe to Zanesville—who cannot find a job and have seen their unemployment insurance run out.

Wilkins writes:

I'm sick of high insurance premiums. I worked for 38 years and now I have no health care coverage.

They threw me away like an old shoe. It's me today and it could be anyone tomorrow.

I may not have three years to live until I receive Medicare if I can't afford my medicine.

I need health reform now. It just can't wait.

One of the other themes that runs through these letters is that people who are in their late fifties or early sixties and do not have insurance are just praying—praying—they can get enough help and stay well enough, stay healthy enough so they can make it until they are 65 and they can get Medicare.

What does that say? Wilkins from Youngstown worked for 38 years. He lost his job because of what has happened in the steel industry. He cannot afford COBRA. He cannot afford his blood pressure medicine. He is working part-time jobs just to try to get by. He is praying he can get to 65 so he can get health insurance under Medicare—a program that looks a lot like the public option would look if we pass that legislation in the next couple of months.

Robin from Cuyahoga County, in the Cleveland area, writes:

My son just graduated from college and his coverage under his Dad's employer is coming to an end.

While he has found an entry level job, he is not currently a full-time employee and does not have health insurance.

He is incredibly healthy, but when he was in high school he was diagnosed with a heart condition, which could require surgery as he ages, but not for decades [his doctor believes].

As my son was searching for insurance, he was honest about this condition. Each company he called denied him.

So now, a 22-year-old with no history of any illness—

A young man, 4 or 5 years older than the pages who sit in front of us—

but who at some point in the future might need medical support, can't get health insurance.

Instead of creating a system that provides him incentives and proactive monitoring of his condition—

To keep him as healthy as we can—

we have a system that drives him away, doesn't encourage preventive measures, and ends up costing everyone more. I encourage you to take every action possible to put an end to health insurance companies denying coverage for preexisting conditions. We need a system that puts an emphasis on preventive care.

Robin is right about her son. Under our health care bill, as the Presiding Officer from Alaska understands, anyone who chooses to can stay on his mother's or father's health insurance until reaching the age of 26. So her son would have 4 more years on their health care plan under our bill that we are going to debate on this floor in the next few weeks. Robin's son would be able to keep his insurance until he was able, down the line, to get a better job with insurance. Obviously, under our bill, he is going to have access to insurance anyway. But one of the things to help young people as they go into the workforce—maybe they are living at home, just moved out of the house, finishing college or coming home from the military, but so many young people lose insurance because they are working at often low-paying jobs that don't provide insurance for their employees.

Beatrice from Summit County, the Akron area, writes:

As a recent retiree due to economic downsizing, I am left to purchase an expensive insurance plan. But I am not sure how

much longer I will be able to pay for the premiums. I only recently got a temporary contractor job that can end at any time.

After 37 years of employment with the same company, it is sad to think that after all those years, I am unable to afford to pay my insurance premiums and unable to collect my Social Security since I retired early.

As my anxiety and stress increase, additional health problems have surfaced. I am not old enough to qualify for Medicare and unable to afford private insurance or COBRA.

I'm asking for your help in supporting health reform that benefits all Americans.

Beatrice is another example. She has worked for a company—as did Wilkins from Youngstown, who worked for some 30-plus years, 38 years. Beatrice from the Akron area has worked at the same place for 37 years. Both lost their jobs. Both can't afford COBRA. Both can't get insurance. Both are seeing their health compromised.

If you have worked someplace for 30 years and you are in your 50s and you are hoping you can stay alive and stay more or less healthy until you are 65, think of the stress that comes with that; the stress of trying to find insurance; the stress of fighting with insurance companies if you do have a preexisting condition or they put a cap on their coverage and what that does to people's health care. No place in the world, no developed, wealthy nation such as ours puts their citizens through these constant battles with insurance companies, these unending fights when insurance companies do all they can to take coverage away from people who thought they had coverage.

I spoke to the Fendlay Rotary today in a community in northwest Ohio which experienced terrible flooding a couple of years ago and I am working with them to help with the Army Corps of Engineers to get a flood mitigation project put together so these floods don't continue to happen on the Blanchard River. We were talking about the insurance industry.

I don't dislike the insurance industry. I think they do what they have to do because they compete with one another and each does these same business practices. But understand, first, they don't want to cover you if you are not healthy. They would rather not write an insurance policy if you are not healthy, so they hire all kinds of people to make sure they don't take you if you have a preexisting condition or if they think you are going to be an expensive risk. That is on the one hand. Then on the other hand, if you have already been insured by this company, if you already have insurance, they have a whole battery of employees who are there to try to deny coverage. I read the other day that close to 30 percent of claims are initially denied by insurance companies—30 percent. So the insurance industry spends all this money to keep people out who are sick, whom they don't want to insure, to find out if there is any preexisting condition or other reasons not to insure them; and then they hire a whole battery of people to try to deny payment, to deny claims if you have an expensive claim against the insurance company.

Again, no other country in the world does that. A lot of countries rely on private insurance, but they are private not-for-profit insurance companies. They are not companies that try to exclude you from getting coverage, and then if you have coverage and you get really sick, try to cut you off so you don't get your costs paid for, you don't get your claims paid for. It is simply a business model that works for the insurance industry, but it sure doesn't work for the American public. It doesn't work for people who thought they had decent insurance.

The last letter I will read comes from James. James writes:

I've paid all of my life for health insurance and now I can't afford it because I'm unemployed. Because I had no insurance, I've had to go to the emergency room, which cost me over $1,300. I've worked and had health care all my life and now I'm told it could cost me $100 up front to even be seen by a doctor. We need a health care system that works for all of us.

One story, one letter after another. I know when the Presiding Officer is in Fairbanks or Anchorage or anywhere around Alaska, he is hearing the same thing from people, through letters and individual conversations from so many people who thought they had good insurance, only to find out they don't when they get sick; people who are just hanging on until they can get a good government plan, Medicare, when they turn 65; people who have worked hard all of their lives and played by the rules and feel like a discarded old shoe, as the gentleman from Youngstown wrote.

I think about what our health care plan will do and how we are going to change the system and make it work for these four people in Ohio and for hundreds of millions of people around the country, where anyone who is satisfied with their health insurance under our plan will be able to keep it, and at the same time we are going to build consumer protections around those plans. We are going to ban certain practices, including no more preexisting condition exclusions, no more discrimination based on disability and gender and geography and age and race or anything else. No more saying to women, You can't get coverage because you were a victim of domestic violence and that is a preexisting condition. Believe it or not, insurance companies do that sometimes. No more saying to a woman who had a C-section, Sorry, you can't get insurance, that is a preexisting condition because the next baby will have to be a C-Section again and that is too expensive for us.

The second thing the bill will do with consumer protections built around it is it will assist small business, giving incentives to small businesses to cover employees.

Third, this legislation will provide insurance for people who don't have coverage or who are dissatisfied with their coverage.

Fourth, this legislation will provide a public option so that anyone who chooses can go into the public plan, not necessarily go to CIGNA or Aetna or United or Medical Mutual in my State, or one of the private insurance companies. That means when people have the public option, it will keep the insurance industry honest because they won't get away with gaming the system because they have a competitor such as the public option that will compete directly with them. It will mean the public option will help to drive prices down because it will make private insurance more affordable, more efficient. Private insurance companies will no longer be able, because of the competition, to pay $24 million CEO salaries such as Aetna does and so many other private insurance companies do. It will mean that people have more choice in southwest Ohio.

In the Cincinnati-Dayton area, there are two insurance companies that provide 85 percent of the insurance and that is simply not competitive. That is why these monopolistic practices that insurance companies engage in so often run counter to the public interests. That is why the public option is so important: to get people choice, to discipline the insurance companies, to bring in competition, to keep prices down, and it will matter as we move forward.

I thank the Presiding Officer for the time on the Senate floor. This legislation will be debated over the next couple of weeks. We know that 70 percent or two-thirds of the American public want a public option. We know a poll by the Robert Wood Johnson Foundation says more than 70 percent of doctors want a public option. We know an overwhelming number of Democrats of both the Senate and House, 90 percent, support a public option. As I said, almost two-thirds of the public, through consistent polling for the last month, and month after month after month, shows that two-thirds of the public support the public option. It makes sense. It makes a good health care bill that much better. It makes the system work that much better for people who have insurance now and people who don't have insurance, but especially all of us who worry so much about the health care costs in this country and how they have spiraled out of control.

I thank the President and yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

UNANIMOUS CONSENT AGREEMENT—S. 1776

Mr. BROWN. Mr. President, I ask unanimous consent that the cloture

vote on the motion to proceed to S. 1776 occur at a time to be determined with the concurrence of the two leaders.

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

UNANIMOUS CONSENT AGREEMENT—H.R. 2892

Mr. BROWN. Mr. President, I ask unanimous consent that on Tuesday, October 20, following a period of morning business, the Senate proceed to the consideration of the conference report to accompany H.R. 2892, the Homeland Security Appropriations Act, with debate on the conference report limited to 3 hours and 15 minutes, with the time divided as follows: 1 hour under the control of the majority leader or his designee, and 2 hours and 15 minutes under the control of the Republican leader or his designee; that if any points of order are raised, any votes on the motions to waive occur upon the use or yielding back of all time identified above; further, that upon disposition of the points of order, and if the motions to waive are successful, the Senate then vote immediately on adoption of the conference report, with 2 minutes of debate, equally divided and controlled, prior to any sequence of votes with respect to the conference report.

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

IRAN REFINED PETROLEUM SANCTIONS ACT

Mr. KYL. Mr. President, in the coming weeks, the Senate will consider S. 908, the Iran Refined Petroleum Sanctions Act. Passing this bill should not be difficult 76 Members of this body are registered as cosponsors—but it is vital that we do.

I support strong sanctions to build pressure on Iran to end its illegal nuclear weapons program, which, in light of the recent disclosure of the Qom uranium enrichment facility, may be far more advanced than we realize.

However, China and Russia continue to thwart meaningful action in the United Nations Security Council. As Bob Robb, a columnist for the Arizona Republic notes, both nations have commercial ties to the Iranian regime and are unlikely to abandon their interests and assist the United States in building pressure on the Iran.

Mr. Robb also emphasizes that U.S. efforts to halt Iran's nuclear program have taken on a new urgency after the President cancelled the deployments of the ground-based interceptors to Poland and the Czech Republic.

Had the President managed to get support from Russia for more sanctions on Iran in exchange for sacrificing missile defense, things might look different. However, as shown by Secretary Clinton's recent visit to Moscow, Russia's position has not changed, and the U.S. has nothing to show for breaking its strategic commitments with two important allies.

Time is not on the administration's side. Every day the Iranians stockpile more uranium and get closer to having long-range missiles capable of delivering the world's most dangerous weapons against our allies, our deployed forces, and our homeland. The time to act is now.

Mr. President, I ask unanimous consent that the op-ed by Mr. Robb be printed in the RECORD.

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

IRAN A TEST OF OBAMA'S NEW DIPLOMACY

(By Robert Robb)

Iran is providing a premature and very high-risk test of President Barack Obama's new approach to American diplomacy.

Simplified, the thesis of the new Obama approach is that if the United States plays nicer with others, others will play nicer with us and be more willing to help do tough things.

I've never held out much hope for the Obama approach. I believe that nations generally act in their self-interest without regard to sentiments about other countries.

On the other hand, the Bush administration's blustery approach only made the rest of the world more hostile and resentful, which wasn't in our self-interest. So, it was worth giving the Obama approach a whirl.

The Obama approach, however, was intended to generate good will over time. The United States would cooperate more on international issues such as climate change and in international organizations such as the U.N. We would engage in direct diplomacy with troublesome regimes such as in Iran, North Korea, Syria, Venezuela and Cuba, all of which Obama said would receive presidential meetings in his first year in office.

After showing good will and willingness to engage in direct diplomacy, the rest of the world would be more willing to support the United States if tougher efforts to rein in dangerous rogue behavior nevertheless proved necessary, went the theory.

Iran has spoiled and short-circuited the rollout of the new Obama diplomacy. The disputed Iranian election made it difficult to engage in direct diplomacy with the current government without appearing to give the back of the hand to those risking their lives to protest its illegitimacy. Iranian President Mahmoud Ahmadinejad stepped up his attacks on Israel's right to exist. And Iran remains unflinching and deceitful about its rapidly-developing nuclear program.

So, the Obama administration is going to have to test its new diplomatic approach before laying all the prerequisites by trying to organize strong sanctions against Iran. It increased the stakes for such diplomacy greatly by abandoning the missile defense complex in Poland at least in part, it seems clear, to induce greater cooperation on Iran by Russia.

Sanctions would have to be crippling to have any hope of forcing Iran to abandon its nuclear ambitions. Only the equivalent of a non-military embargo on gasoline imports is thought to have sufficient effect to possibly get the job done.

To be effective, a ban on Iranian gasoline imports would require extraordinary international cooperation. Western powers might adopt them, and indeed Western suppliers have already been cutting ties to Iran. But gasoline is transportable and tradable, so masking its origins is difficult but doable.

The national interest calculations would suggest that Russia and China are unlikely to go along with potentially effective sanctions against Iran, officially or unofficially. Iran is a client of Russia's on nuclear technology and military apparatus. China is a client for Iranian oil, which provides 15 percent of China's crude supplies.

They also have the interest Robert Kagan has cited that all autocratic regimes have in thwarting efforts to pressure and delegitimize other autocratic regimes.

The need to very quickly cobble together an effective sanctions regimen against Iran is an unfair test of Obama's new approach. But it's the test that has to be taken.

If the effort to impose effective sanctions fails, as it is likely to do, the Russian gambit will prove very costly.

If sanctions fail and Israel doesn't act, the world may have to live with an Iran capable of producing a nuclear weapon. In that world, the Poland missile defense complex would have been very valuable.

The Obama administration said that it was abandoning the Poland complex designed to shoot down long-range missiles because the intelligence suggested Iran has slowed down the development of its long-range capability. It's hard to credit that. Iran has successfully tested a two-stage rocket and put a satellite in space.

Theater missile defense, which the Obama administration says it will emphasize more, is important. But in a world with a nuclear-capable Iran, so is the European missile defense against long-range threats the Obama administration just abandoned.

ADDITIONAL STATEMENTS

TRIBUTE TO LOUISIANA WWII VETERANS

• Ms. LANDRIEU. Mr. President, I am proud to honor a group of 92 World War II veterans from all over Louisiana who travelled to Washington, DC, on October 10 to visit the various memorials and monuments that recognize the sacrifices of our Nation's invaluable servicemembers.

Louisiana HonorAir, a group based in Lafayette, LA, sponsored this trip to the Nation's Capital. The organization is honoring surviving World War II Louisiana veterans by giving them an opportunity to see the memorials dedicated to their service. The veterans visited the World War II, Korea, Vietnam, and Iwo Jima Memorials. They also traveled to Arlington National Cemetery.

This was the second of three flights Louisiana HonorAir made to Washington, DC, this fall. It is the 19th flight to depart from Louisiana, which has sent more HonorAir flights than any other State to the Nation's Capital.

World War II was one of America's greatest triumphs but was also a conflict rife with individual sacrifice and tragedy. More than 60 million people worldwide were killed, including 40 million civilians, and more than 400,000 American servicemembers were slain during the long war. The ultimate victory over enemies in the Pacific and in Europe is a testament to the valor of American soldiers, sailors, airmen, and

marines. The years 1941 to 1945 also witnessed an unprecedented mobilization of domestic industry, which supplied our military on two distant fronts.

In Louisiana, there remain today about 30,000 living WWII veterans, and each one has a heroic tale of achieving the noble victory of freedom over tyranny. This group had 36 veterans who served in the U.S. Army, 14 in the Army Air Corps, 34 in the Navy, 4 in the Marine Corps, one in the Merchant Marines, one in the Coast Guard, and 2 were a part of Women Accepted for Volunteer Emergency Services, WAVES.

Our heroes, many of them from South Louisiana, trekked the world for their country. They fought in Germany, Holland, France, Italy, Africa, Guam, Bougainville, Guadalcanal, Iwo Jima, Okinawa, the Philippines, New Guinea, Japan, and Saipan. Their journeys included the invasions of North Africa, Sicily, and Normandy.

One of our Army Air Corps was held as a prisoner of war after his aircraft was shot down over Germany. Three other Army veterans fought bravely in the Battle of the Bulge, all three receiving a Purple Heart and one receiving three Bronze stars for his service.

One Navy veteran earned 10 medals for his service in the Pacific. An Army Air Corps veteran served in 20 combat missions in Europe between 1942 and 1955. Another Navy veteran was present for the surrender at Tokyo Bay in 1945.

One Navy veteran was serving in Pearl Harbor during the infamous Japanese attack in 1941. Eight veterans received Purple Hearts and five of them were held as prisoners of war.

I am also proud to acknowledge that of the 92 veterans who visited Washington this past weekend, 2 were women who served our country with honor and distinction during World War II.

I ask the Senate to join me in honoring these 92 veterans, all Louisiana heroes, who visited Washington, and Louisiana HonorAir for making these trips a reality.●

TRANSMITTING NOTIFICATION OF THE CONTINUATION OF THE NATIONAL EMERGENCY WITH RESPECT TO THE EMERGENCY DECLARED PERTAINING TO SIGNIFICANT NARCOTICS TRAFFICKERS CENTERED IN COLOMBIA TO CONTINUE IN EFFECT BEYOND OCTOBER 21, 2009, AS RECEIVED DURING ADJOURNMENT OF THE SENATE ON OCTOBER 16, 2009—PM 33

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States which was referred to the Committee on Banking, Housing, and Urban Affairs:

To the Congress of the United States:

Section 202(d) of the National Emergencies Act, 50 U.S.C. 1622(d), provides for the automatic termination of a national emergency unless, prior to the anniversary date of its declaration, the President publishes in the *Federal Register* and transmits to the Congress a notice stating that the emergency is to continue in effect beyond the anniversary date. In accordance with this provision, I have sent to the *Federal Register* for publication the enclosed notice stating that the emergency declared with respect to significant narcotics traffickers centered in Colombia is to continue in effect beyond October 21, 2009.

The circumstances that led to the declaration on October 21, 1995, of a national emergency have not been resolved. The actions of significant narcotics traffickers centered in Colombia continue to pose an unusual and extraordinary threat to the national security, foreign policy, and economy of the United States and to cause an extreme level of violence, corruption, and harm in the United States and abroad. For these reasons, I have determined that it is necessary to maintain economic pressure on significant narcotics traffickers centered in Colombia by blocking their property and interests in property that are in the United States or within the possession or control of United States persons and by depriving them of access to the U.S. market and financial system.

BARACK OBAMA.

THE WHITE HOUSE, *October 16, 2009*.

REPORT RELATIVE TO THE HAITIAN HEMISPHERIC OPPORTUNITY THROUGH PARTNERSHIP ENCOURAGEMENT ACT OF 2008 (HOPE II) (P.L. 110–246) THAT AMENDED THE CARIBBEAN BASIN ECONOMIC RECOVERY ACT (CBERA) MAKING CERTAIN ADDITIONAL PRODUCTS FROM HAITI ELIGIBLE FOR PREFERENTIAL TARIFF TREATMENT AFTER OCTOBER 18, 2009, AS RECEIVED DURING THE ADJOURNMENT OF THE SENATE ON OCTOBER 16, 2009—PM 34

The PRESIDING OFFICER laid before the Senate the following message from the President of The United States which was referred to the Committee on Finance:

To the Congress of the United States:

The Haitian Hemispheric Opportunity through Partnership Encouragement Act of 2008 (HOPE II) (the ''Act'') (Public Law 110–246), amended the Caribbean Basin Economic Recovery Act (CBERA) to make certain additional products from Haiti eligible for preferential tariff treatment. Under HOPE II, these imports from Haiti will continue to be eligible for preferential treatment after October 18, 2009, if I determine and certify that Haiti has met certain eligibility criteria set out in the Act.

Since enactment of HOPE II, Haiti has issued a decree establishing an independent labor ombudsman's office, and the President of Haiti has selected a labor ombudsman following consultation with unions and industry representatives. In addition, Haiti, in cooperation with the International Labor Organization, has established a Technical Assistance Improvement and Compliance Needs Assessment and Remediation (TAICNAR) Program. Haiti has also implemented an electronic visa system that acts as a registry of Haitian producers of articles eligible for duty-free treatment and has made participation in the TAICNAR Program a condition of using this visa system.

In light of these actions and in accordance with section 213A of CBERA, as amended, I have determined and hereby certify that Haiti: (i) has implemented the requirements set forth in sections 213A(e)(2) and (e)(3); and (ii) is requiring producers of articles for which duty-free treatment may be requested under section 213A(b) to participate in the TAICNAR Program and has developed a system to ensure participation in such program by such producers, including by developing and maintaining a registry of producers.

BARACK OBAMA.

THE WHITE HOUSE, *October 16, 2009*.

MESSAGE FROM THE HOUSE

At 2:03 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2442. An act to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to expand the Bay Area Regional Water Recycling Program, and for other purposes.

MEASURES REFERRED

The following bill was read the first and the second times by unanimous consent, and referred as indicated:

H.R. 2442. An act to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to expand the Bay Area Regional Water Recycling Program, and for other purposes; to the Committee on Energy and Natural Resources.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3416. A communication from the Secretary, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Internal Control Over Financial Reporting in Exchange Act Periodic Reports of Non-Accelerated Filers'' (RIN3235–AK48) received in the Office of the President of the Senate on October 14, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3417. A communication from the Attorney Advisor, U.S. Coast Guard, Department

of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Quarterly Listings; Safety Zones; Security Zones; Special Local Regulations; Regulated Navigation Areas; Drawbridge Operation Regulations'' (Docket No. USG–2009–0909) received in the Office of the President of the Senate on October 14, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3418. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Air Quality Designations for the 2006 24-Hour Fine Particle (PM2.5) National Ambient Air Quality Standards'' (FRL No. 8969–2) received in the Office of the President of the Senate on October 15, 2009; to the Committee on Environment and Public Works.

EC–3419. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; South Carolina; Clear Air Interstate Rule'' (FRL No. 8969–9) received in the Office of the President of the Senate on October 15, 2009; to the Committee on Environment and Public Works.

EC–3420. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Revisions to the California State Implementation Plan, San Joaquin Valley Unified Air Pollution Control District'' (FRL No. 8959–7) received in the Office of the President of the Senate on October 15, 2009; to the Committee on Environment and Public Works.

EC–3421. A communication from the Secretary of the Department of Health and Human Services, transmitting the report of proposed legislation relative to Multilateral Child Support Convention Implementation; to the Committee on Finance.

EC–3422. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed amendment to a technical assistance agreement for the export of defense articles, including, technical data, and defense services to Finland relative to the integration of surfaced launched AMRAAM electronics kits in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. BAUCUS, from the Committee on Finance, without amendment:

S. 1796. An original bill to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes (Rept. No. 111–89).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BAUCUS:

S. 1796. An original bill to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes; from the Committee on Finance; placed on the calendar.

By Mr. LUGAR:

S. 1797. A bill to extend the temporary reduction of the duty on certain textured rolled glass sheets; to the Committee on Finance.

By Mr. SANDERS:

S. 1798. A bill to provide for the automatic enrollment of demobilizing members of the National Guard and Reserve in health care and dental care programs of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. DODD (for himself, Mr. SCHUMER, Mr. REED, Mr. BROWN, Mr. LEVIN, Mr. MERKLEY, Mr. MENENDEZ, and Mr. REID):

S. 1799. A bill to amend the Truth in Lending Act, to establish fair and transparent practices related to the marketing and provision of overdraft coverage programs at depository institutions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. DODD (for himself, Mr. GRASSLEY, Mr. BROWN, Mr. ENZI, Mr. CASEY, Mr. ALEXANDER, Mr. LEVIN, Ms. MURKOWSKI, Mr. ROCKEFELLER, Mr. INHOFE, Mr. LIEBERMAN, Mr. BROWNBACK, Mr. JOHNSON, Mr. CORNYN, Ms. STABENOW, and Mr. PRYOR):

S. Res. 314. A resolution designating the week beginning October 18, 2009, as ''National Character Counts Week''; considered and agreed to.

ADDITIONAL COSPONSORS

S. 148

At the request of Mr. KOHL, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 148, a bill to restore the rule that agreements between manufacturers and retailers, distributors, or wholesalers to set the minimum price below which the manufacturer's product or service cannot be sold violates the Sherman Act.

S. 254

At the request of Mrs. LINCOLN, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 254, a bill to amend title XVIII of the Social Security Act to provide for the coverage of home infusion therapy under the Medicare Program.

S. 456

At the request of Mr. DODD, the names of the Senator from New Jersey (Mr. MENENDEZ) and the Senator from North Carolina (Mrs. HAGAN) were added as cosponsors of S. 456, a bill to direct the Secretary of Health and Human Services, in consultation with the Secretary of Education, to develop guidelines to be used on a voluntary basis to develop plans to manage the risk of food allergy and anaphylaxis in schools and early childhood education programs, to establish school-based food allergy management grants, and for other purposes.

S. 607

At the request of Mr. UDALL of Colorado, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 607, a bill to amend the National Forest Ski Area Permit Act of 1986 to clarify the authority of the Secretary of Agriculture regarding additional recreational uses of National Forest System land that are subject to ski area permits, and for other purposes.

S. 795

At the request of Mrs. LINCOLN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 795, a bill to amend the Social Security Act to enhance the social security of the Nation by ensuring adequate public-private infrastructure and to resolve to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation, and for other purposes.

S. 823

At the request of Ms. SNOWE, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 823, a bill to amend the Internal Revenue Code of 1986 to allow a 5-year carryback of operating losses, and for other purposes.

S. 825

At the request of Mrs. LINCOLN, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 825, a bill to amend the Internal Revenue Code of 1986 to restore, increase, and make permanent the exclusion from gross income for amounts received under qualified group legal services plans.

S. 883

At the request of Mr. KERRY, the names of the Senator from Virginia (Mr. WEBB), the Senator from Florida (Mr. LEMIEUX), the Senator from New Jersey (Mr. LAUTENBERG) and the Senator from Virginia (Mr. WARNER) were added as cosponsors of S. 883, a bill to require the Secretary of the Treasury to mint coins in recognition and celebration of the establishment of the Medal of Honor in 1861, America's highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Services of the United States, to honor the American military men and women who have been recipients of the Medal of Honor, and to promote awareness of what the Medal of Honor represents and how ordinary Americans, through courage, sacrifice, selfless service and patriotism, can challenge fate and change the course of history.

S. 941

At the request of Mr. CRAPO, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 941, a bill to reform the Bureau of Alcohol, Tobacco, Firearms, and Explosives, modernize firearm laws and regulations, protect the community from criminals, and for other purposes.

S. 1151

At the request of Mr. ROCKEFELLER, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1151, a bill to amend part A of title IV of the Social Security Act to require the Secretary of Health and Human Services to conduct research on indicators of child well-being.

S. 1215

At the request of Mr. CASEY, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 1215, a bill to amend the Safe Drinking Water Act to repeal a certain exemption for hydraulic fracturing, and for other purposes.

S. 1321

At the request of Mr. UDALL of Colorado, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 1321, a bill to amend the Internal Revenue Code of 1986 to provide a credit for property labeled under the Environmental Protection Agency Water Sense program.

S. 1340

At the request of Mr. LEAHY, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1340, a bill to establish a minimum funding level for programs under the Victims of Crime Act of 1984 for fiscal years 2010 to 2014 that ensures a reasonable growth in victim programs without jeopardizing the long—term sustainability of the Crime Victims Fund.

S. 1583

At the request of Mr. ROCKEFELLER, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 1583, a bill to amend the Internal Revenue Code of 1986 to extend the new markets tax credit through 2014, and for other purposes.

S. 1589

At the request of Ms. CANTWELL, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1589, a bill to amend the Internal Revenue Code of 1986 to modify the incentives for the production of biodiesel.

S. 1660

At the request of Ms. KLOBUCHAR, the names of the Senator from Louisiana (Mr. VITTER) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 1660, a bill to amend the Toxic Substances Control Act to reduce the emissions of formaldehyde from composite wood products, and for other purposes.

S. 1666

At the request of Ms. COLLINS, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 1666, a bill to require the Administrator of the Environmental Protection Agency to satisfy certain conditions before issuing to producers of mid—level ethanol blends a waiver from certain requirements under the Clean Air Act, and for other purposes.

S. 1672

At the request of Mr. REED, the names of the Senator from North Carolina (Mr. BURR) and the Senator from Rhode Island (Mr. WHITEHOUSE) were added as cosponsors of S. 1672, a bill to reauthorize the National Oilheat Research Alliance Act of 2000.

S. 1678

At the request of Mr. CARDIN, the names of the Senator from Maryland (Ms. MIKULSKI) and the Senator from New Mexico (Mr. UDALL) were added as cosponsors of S. 1678, a bill to amend the Internal Revenue Code of 1986 to extend the first-time homebuyer tax credit, and for other purposes.

S. 1685

At the request of Mr. SANDERS, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 1685, a bill to provide an emergency benefit of $250 to seniors, veterans, and persons with disabilities in 2010 to compensate for the lack of a cost-of-living adjustment for such year, and for other purposes.

S. 1700

At the request of Mr. LUGAR, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 1700, a bill to require certain issuers to disclose payments to foreign governments for the commercial development of oil, natural gas, and minerals, to express the sense of Congress that the President should disclose any payment relating to the commercial development of oil, natural gas, and minerals on Federal land, and for other purposes.

S. 1711

At the request of Mr. REID, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 1711, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for making homes more water-efficient, for building new water-efficient homes, for public water conservation, and for other purposes.

S. 1731

At the request of Mr. REED, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 1731, a bill to require certain mortgagees to make loan modifications, to establish a grant program for State and local government mediation programs, to create databases on foreclosures, and for other purposes.

S. 1761

At the request of Ms. LANDRIEU, the name of the Senator from Mississippi (Mr. WICKER) was added as a cosponsor of S. 1761, a bill to provide an extension of the low-income housing credit placed-in-service date requirement for certain disaster areas.

S. 1763

At the request of Mr. FRANKEN, the names of the Senator from Alaska (Mr. BEGICH) and the Senator from New Mexico (Mr. UDALL) were added as cosponsors of S. 1763, a bill to amend the Internal Revenue Code of 1986 to deny the deduction for advertising and promotional expenses for prescription pharmaceuticals.

S. 1765

At the request of Mr. CARDIN, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 1765, a bill to amend the Hate Crime Statistics Act to include crimes against the homeless.

S. 1777

At the request of Mr. UDALL of Colorado, the name of the Senator from Idaho (Mr. RISCH) was added as a cosponsor of S. 1777, a bill to facilitate the remediation of abandoned hardrock mines, and for other purposes.

S. 1790

At the request of Mr. DORGAN, the name of the Senator from Colorado (Mr. BENNET) was added as a cosponsor of S. 1790, a bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

S. RES. 312

At the request of Mr. DURBIN, the names of the Senator from Vermont (Mr. SANDERS) and the Senator from Ohio (Mr. VOINOVICH) were added as cosponsors of S. Res. 312, a resolution expressing the sense of the Senate on empowering and strengthening the United States Agency for International Development (USAID).

AMENDMENT NO. 2668

At the request of Mr. UDALL of New Mexico, his name was added as a cosponsor of amendment No. 2668 intended to be proposed to H.R. 3548, a bill to amend the Supplemental Appropriations Act, 2008 to provide for the temporary availability of certain additional emergency unemployment compensation, and for other purposes.

AMENDMENT NO. 2679

At the request of Ms. KLOBUCHAR, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of amendment No. 2679 intended to be proposed to H.R. 2847, a bill making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DODD (for himself, Mr. SCHUMER, Mr. REED, Mr. BROWN, Mr. LEVIN, Mr. MERKLEY, Mr. MENENDEZ, and Mr. REID):

S. 1799. A bill to amend the Truth in Lending Act, to establish fair and transparent practices elated to the marketing and provision of overdraft coverage programs at depository insitutions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. DODD. Mr. President, I rise to introduce the Fairness and Accountability in Receiving Overdraft Coverage Act, The FAIR Overdraft Coverage Act. The FAIR Overdraft Coverage Act will rein in abusive fees, give customers greater choice, and bring

greater transparency to overdraft coverage programs.

For too long, some in the financial services industry have gotten rich by taking advantage of consumers.

Earlier this year, in a 90–5 vote, this body passed legislation to crack down on credit card companies who were charging excessive fees and indiscriminately raising customers' rates. Those practices were wrong, and I was proud to lead the charge to put a stop to them.

Today, I hope to rally my colleagues' support to curtail another abusive practice: overdraft fees.

Let me be clear, people have a responsibility to spend within their means.

However, too often, banks take advantage of their customers under the guise of providing the ''service'' of overdraft protection, a service that the customer may not want and may not even know has been applied to his or her account.

The Financial Times recently reported that banks stand to collect a record $38.5 billion in overdraft fees this year.

According to the Center for Responsible Lending, nearly $1 billion of that will come from young adults.

Another $4.5 billion will come from senior citizens like Mario Livieri of Branford, Connecticut. Mario is a 75–year-old retired homebuilder who accidentally overdrew his account by approximately $2, and was charged $35 by his bank. The bank took several days to notify him that the account was overdrawn, and in the meantime, he made three additional minor purchases for which he was charged three additional $35 fees—a total of $140.

When Mario protested, the bank waived one of the four $35 charges. They told him there was nothing more he could do to fight the fees, because this practice was perfectly legal. Mario Livieri is no longer a customer at that bank, and this prevalent practice should no longer be perfectly legal.

Slow-walking notifications to consumers when their accounts are overdrawn is just one way in which banks try to run up the score on overdraft fees. Sometimes, they even re-arrange the order in which they process your purchases, charging you for a later, larger purchase first and then they charge you repeated overdraft fees for earlier, smaller purchases.

Worst of all, so-called ''overdraft protection'' is often added to customers'' accounts without their permission, or even their knowledge. Customers who don't know that this feature is attached to their accounts think their purchases will just be denied if they don't have sufficient money in their accounts. Instead, their depository institutions will let these purchases go through and charge a $35 flat fee for each purchase that overdrafts the account—no matter how small the purchase. And there generally is no limit on the number of fees that a customer can be charged in a single day.

That is just wrong. Families in my State of Connecticut and across the country are already struggling to make ends meet—and these unfair and excessive charges are making it even harder. Over the past few weeks, I've worked with consumer groups and listened to folks like Mario who have been the victims of these abusive practices. Those discussions resulted in the bill I present to you today.

Here is how the bill works.

First and foremost, no consumer should be enrolled in a program like this without their knowledge. My bill will establish an opt-in rule for overdraft protection for ATM and debit transactions so that customers will have to consent before they can be charged an overdraft coverage fee. You will recall that the credit card bill we passed earlier this year had a similar approach to over-the-limit fees.

If you do choose to opt into an overdraft coverage program, the bill will limit the number of overdraft fees banks can charge you—one per month, and no more than six per year. And that fee will be required to be proportional to the cost of processing the overdraft—no more $40 charges for $2 cups of coffee.

My legislation will also put a stop to the practice of manipulating the order in which transactions are posted, and require banks to warn customers if they are about to overdraw their account, giving them a chance to cancel the transaction.

Finally, it will require banks to notify customers promptly when they've overdrawn an account—through a means the customer chooses, from e-mail to text message to letter—so that they can quickly restore their balance and avoid unnecessary fees.

Abusive overdraft policies are unfair, and the banks know it. After it came out in the press that I was working on this legislation, a few of the big banks took steps towards responsible reform.

We will see whether these few are truly committed to reform. America's consumers deserve better—and this legislation will make sure they won't continue to be victims of greedy banks looking to line their pockets at the expense of hard-working families.

I urge my colleagues to join me and Senators HARRY REID, CHARLES SCHUMER, JACK REED, SHERROD BROWN, CARL LEVIN, JEFF MERKLEY, and ROBERT MENENDEZ in support of this legislation.

Mr. President, I ask unanimous Consent that the text of the bill be printed in the RECORD.

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

S. 1799

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Fairness and Accountability in Receiving Overdraft Coverage Act of 2009'' or the ''FAIR Overdraft Coverage Act''.

SEC. 2. FINDINGS AND PURPOSE.

Section 102 of the Truth in Lending Act (15 U.S.C. 1601) is amended by adding at the end the following:

''(c) FAIRNESS AND ACCOUNTABILITY IN OVERDRAFT COVERAGE.—

''(1) FINDINGS.—The Congress also finds that—

''(A) overdraft coverage is a form of short-term credit that depository institutions provide for consumer transaction accounts. Historically, depository institutions covered overdrafts for a fee on an ad hoc basis;

''(B) with the growth in specially designed software programs and in consumer use of debit cards, overdraft coverage for a fee has become more prevalent;

''(C) most depository institutions do not notify consumers when adding this feature to their transaction accounts, and some do not permit consumers to eliminate this feature from such accounts;

''(D) most depository institutions collect a high flat fee, including for small dollar transactions, each time the institution covers an overdraft, in some cases impose multiple overdraft coverage fees within a single day, and many charge additional fees for each day during which the account remains overdrawn; and

''(E) such abusive and misleading practices in connection with overdraft coverage fees have deprived consumers of meaningful choices about their accounts and placed significant financial burdens on low- and moderate-income consumers.

''(2) PURPOSE.—It is the purpose of this title to protect consumers by limiting abusive and misleading overdraft coverage fees and practices, and by providing meaningful disclosures and consumer choice in connection with overdraft coverage fees.''.

SEC. 3. DEFINITIONS.

(a) ADDITIONAL DEFINITIONS.—Section 103 of the Truth in Lending Act (15 U.S.C. 1602) is amended by adding at the end the following:

''(cc) DEFINITIONS RELATING TO OVERDRAFT COVERAGE.—

''(1) CHECK.—The term 'check' has the same meaning as in section 3(6) of the Check Clearing for the 21st Century Act (12 U.S.C. 5001 et seq.), other than a travelers check.

''(2) DEPOSITORY INSTITUTION.—The term 'depository institution' has the same meaning as in clauses (i) through (vi) of section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A)).

''(3) NONSUFFICIENT FUND FEE.—The term 'nonsufficient fund fee' means a fee or charge assessed in connection with an overdraft for which a depository institution declines payment.

''(4) OVERDRAFT.—The term 'overdraft' means the amount of a withdrawal by check or other debit from a transaction account in which there are insufficient or unavailable funds in the account to cover such check or debit.

''(5) OVERDRAFT COVERAGE.—The term 'overdraft coverage' means the payment of a check presented or other debit posted against a transaction account by the depository institution in which such account is held, even though there are insufficient or unavailable funds in the account to cover such checks or other debits.

''(6) OVERDRAFT COVERAGE FEE.—The term 'overdraft coverage fee' means any fee or charge assessed in connection with overdraft coverage, or in connection with any negative account balance that results from overdraft coverage, excluding fees or charges relating to overdraft lines of credit or transfers from an account linked to another transaction account or line of credit. Such fee shall be considered a 'finance charge' for purposes of section 106(a), but shall not be included in the

calculation of the rate of interest for purposes of section 107(5)(A)(vi) of the Federal Credit Union Act (12 U.S.C. 1757(5)(A)(vi)).

''(7) OVERDRAFT COVERAGE PROGRAM.—The term 'overdraft coverage program' means a service under which a depository institution assesses an overdraft coverage fee for overdraft coverage.

''(8) TRANSACTION ACCOUNT.—The term 'transaction account' has the same meaning as in section 19(b)(1)(C) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(C)).''.

(b) CONFORMING AMENDMENT.—Section 107(5)(A)(vi) of the Federal Credit Union Act (12 U.S.C. 1757(5)(A)(vi)) is amended by inserting '', other than an overdraft coverage fee, as defined in section 103(cc) of the Truth in Lending Act (12 U.S.C. 1602(cc))'' after ''inclusive of all finance charges''.

SEC. 4. FAIR MARKETING AND PROVISION OF OVERDRAFT COVERAGE PROGRAMS.

Chapter 2 of the Truth in Lending Act (15 U.S.C. 1631 et seq.) is amended by adding at the end the following new section:

''SEC. 140B. OVERDRAFT COVERAGE PROGRAM DISCLOSURES AND CONSUMER PROTECTION.

''(a) PROHIBITIONS.—No depository institution may engage in acts or practices in connection with the marketing of or the provision of overdraft coverage that are unfair, deceptive, or designed to evade the provisions of this section.

''(b) MARKETING DISCLOSURES.—Each depository institution that provides or offers to provide overdraft coverage with respect to transaction accounts held at that depository institution shall clearly and conspicuously disclose in all marketing materials for such overdraft coverage any overdraft coverage fees.

''(c) CONSUMER CONSENT OPT-IN.—A depository institution may charge overdraft coverage fees with respect to withdrawals from automated teller machines or debit card transfers only if the consumer has consented in writing, in electronic form, or in such other form as is permitted under regulations of the Board.

''(d) CONSUMER DISCLOSURES.—Each depository institution shall clearly disclose to each consumer covered by an overdraft protection program of that depository institution—

''(1) that—

''(A) the consumer may be charged for not more than one overdraft coverage fee in any single calendar month and not more than 6 overdraft coverage fees in any single calendar year, per transaction account; and

''(B) the depository institution retains the discretion to pay (without assessing an overdraft coverage fee) or reject overdrafts incurred by the consumer beyond the numbers described in subparagraph (A);

''(2) information about any alternative overdraft products that are available, including a clear explanation of how the terms and fees for such alternative services and products differ; and

''(3) such other information as the Board may require, by rule.

''(e) PERIODIC STATEMENTS.—Each depository institution that offers an overdraft coverage program shall, in each periodic statement for any transaction account that has an overdraft coverage program feature, clearly disclose to the consumer the dollar amount of all overdraft coverage fees charged to the consumer for the relevant period and year to date.

''(f) EXCLUSION FROM ACCOUNT BALANCE INFORMATION.—No depository institution may include the amount available under the overdraft coverage program of a consumer as part of the transaction account balance of that consumer.

''(g) PROMPT NOTIFICATION.—Each depository institution shall promptly notify consumers, through a reasonable means selected by the consumer, when overdraft coverage has been accessed with respect to the account of the consumer, not later than on the day on which such access occurs, including—

''(1) the date of the transaction;

''(2) the type of transaction;

''(3) the overdraft amount;

''(4) the overdraft coverage fee;

''(5) the amount necessary to return the account to a positive balance; and

''(6) whether the participation of a consumer in an overdraft coverage program will be terminated if the account is not returned to a positive balance within a given time period.

''(h) TERMINATED OR SUSPENDED COVERAGE.—Each depository institution shall provide prompt notice to the consumer, using a reasonable means selected by the consumer, if the institution terminates or suspends access to an overdraft coverage program with respect to an account of the consumer, including a clear rationale for the action.

''(i) NOTICE AND OPPORTUNITY TO CANCEL.—Each depository institution shall—

''(1) warn any consumer covered by an overdraft coverage program who engages in a transaction through an automated teller machine or a branch teller if completing the transaction would trigger overdraft coverage fees, including the amount of the fees; and

''(2) provide to the consumer the opportunity to cancel the transaction before it is completed.

''(j) OVERDRAFT COVERAGE FEE LIMITS.—

''(1) FREQUENCY.—A depository institution may charge not more than one overdraft coverage fee in any single calendar month, and not more than 6 overdraft coverage fees in any single calendar year, per transaction account.

''(2) REASONABLE AND PROPORTIONAL OVERDRAFT COVERAGE FEES.—

''(A) IN GENERAL.—The amount of any overdraft coverage fee that a depository institution may assess for paying a transaction (including a check or other debit) shall be reasonable and proportional to the cost of processing the transaction.

''(B) SAFE HARBOR RULE AUTHORIZED.—The Board, in consultation with the Comptroller of the Currency, the Board of Directors of the Federal Deposit Insurance Corporation, the Director of the Office of Thrift Supervision, and the National Credit Union Administration Board, may issue rules to provide an amount for any overdraft coverage fee that is presumed to be reasonable and proportional to the actual cost of processing the transaction.

''(3) POSTING ORDER.—In order to minimize overdraft coverage fees charged to consumers, each depository institution shall post transactions with respect to transaction accounts in such a manner that the consumer does not incur avoidable overdraft coverage fees.

''(k) DEBIT HOLDS.—No depository institution may charge an overdraft coverage fee on any category of transaction, if the overdraft results solely from a debit hold amount placed on a transaction account that exceeds the actual dollar amount of the transaction.

''(l) NONDISCRIMINATION FOR NOT OPTING IN.—In implementing the requirements of this section, each depository institution shall provide to consumers who have not consented to participate in an overdraft coverage program, transaction accounts having the same terms, conditions, or other features as those that are provided to consumers who have consented to participate in such overdraft coverage program, except for features of such overdraft coverage.

''(m) NON-SUFFICIENT FUND FEE LIMITS.—No depository institution may charge any non-sufficient fund fee with respect to—

''(1) any transaction at an automated teller machine; or

''(2) any debit card transaction.

''(n) REPORTS TO CONSUMER REPORTING AGENCIES.—No depository institution may report negative information regarding the use of overdraft coverage by a consumer to any consumer reporting agency (as that term is defined in section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a)) when the overdraft amounts and overdraft coverage fees are paid under the terms of an overdraft coverage program.

''(o) RULE OF CONSTRUCTION.—No provision of this section may be construed as prohibiting a depository institution from retaining the discretion to pay, without assessing an overdraft coverage fee or charge, an overdraft incurred by a consumer.''.

SEC. 5. REGULATORY AUTHORITY OF THE BOARD.

(a) IN GENERAL.—Not later than 9 months after the date of enactment of this Act (except as provided in subsection (b)), the Board of Governors of the Federal Reserve System (in this Act referred to as the ''Board''), in consultation with the Comptroller of the Currency, the Board of Directors of the Federal Deposit Insurance Corporation, the Director of the Office of Thrift Supervision, and the National Credit Union Administration Board, shall issue such final rules and publish such model forms as necessary to carry out section 140B of the Truth in Lending Act, as added by this Act.

(b) BOARD AUTHORITY REGARDING ADDITIONAL WARNINGS.—The Board may, by rule, after taking into account the findings of the Comptroller General of the United States under section 6, require warnings at locations such as point-of-sale transfer terminals or other locations, that are similar to those required under section 140B(i) of the Truth in Lending Act, as added by this Act, where feasible, and if the cost of providing such warnings does not outweigh the benefit to consumers.

SEC. 6. STUDY AND REPORT BY THE GAO.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study regarding whether it is feasible for a depository institution—

(A) to provide a warning to a consumer at a point-of-sale transfer terminal that completing a transfer may trigger overdraft coverage fees; and

(B) to provide the consumer with the opportunity to cancel the point-of-sale transfer before the transaction is completed.

(2) CONSIDERATIONS.—In conducting the study under this subsection, the Comptroller General shall evaluate—

(A) the benefits to consumers of a point-of-sale transfer overdraft warning and opportunity to cancel;

(B) the availability of technology to provide such a warning and opportunity; and

(C) the cost of providing such warning and opportunity.

(b) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit a report to Congress on the results of the study conducted under subsection (a).

(c) DEFINITIONS.—As used in this section, the terms ''overdraft coverage program'', ''overdraft coverage fee'', and ''depository institution'' have the same meanings as in section 103(cc) of the Truth in Lending Act, as added by this Act.

SEC. 7. EFFECTIVE DATE.

(a) IN GENERAL.—This Act and the amendments made by this Act shall become effective 1 year after the date of enactment of this Act, whether or not the rules of the Board under this Act or such amendments are issued in final form.

(b) MORATORIUM ON FEE INCREASES.—

(1) IN GENERAL.—During the 1-year period beginning on the date of enactment of this Act, no depository institution may increase the overdraft coverage fees or charges assessed on transaction accounts for paying a transaction (including a check or other debit) in connection with an overdraft or for non-sufficient funds.

(2) DEFINITIONS.—As used in this section, the terms ''depository institution'', ''overdraft'', ''overdraft coverage fee'', ''transaction account'' and ''nonsufficient fund fee'' have the same meanings as in section 103(cc) of the Truth in Lending Act, as added by this Act.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 314—DESIGNATING THE WEEK BEGINNING OCTOBER 18, 2009, AS ''NATIONAL CHARACTER COUNTS WEEK''

Mr. DODD (for himself, Mr. GRASSLEY, Mr. BROWN, Mr. ENZI, Mr. CASEY, Mr. ALEXANDER, Mr. LEVIN, Ms. MURKOWSKI, Mr. ROCKEFELLER, Mr. INHOFE, Mr. LIEBERMAN, Mr. BROWNBACK, Mr. JOHNSON, Mr. CORNYN, Ms. STABENOW, and Mr. PRYOR) submitted the following resolution; which was considered and agreed to:

S. RES. 314

Whereas the well-being of the United States requires that the young people of this Nation become an involved, caring citizenry of good character;

Whereas the character education of children has become more urgent, as violence by and against youth increasingly threatens the physical and psychological well-being of the people of the United States;

Whereas more than ever, children need strong and constructive guidance from their families and their communities, including schools, youth organizations, religious institutions, and civic groups;

Whereas the character of a nation is only as strong as the character of its individual citizens;

Whereas the public good is advanced when young people are taught the importance of good character and the positive effects that good character can have in personal relationships, in school, and in the workplace;

Whereas scholars and educators agree that people do not automatically develop good character and that, therefore, conscientious efforts must be made by institutions and individuals that influence youth to help young people develop the essential traits and characteristics that comprise good character;

Whereas although character development is, first and foremost, an obligation of families, the efforts of faith communities, schools, and youth, civic, and human service organizations also play an important role in fostering and promoting good character;

Whereas Congress encourages students, teachers, parents, youth, and community leaders to recognize the importance of character education in preparing young people to play a role in determining the future of the United States;

Whereas effective character education is based on core ethical values, which form the foundation of democratic society;

Whereas examples of character are trustworthiness, respect, responsibility, fairness, caring, citizenship, and honesty;

Whereas elements of character transcend cultural, religious, and socioeconomic differences;

Whereas the character and conduct of our youth reflect the character and conduct of society, and, therefore, every adult has the responsibility to teach and model ethical values and every social institution has the responsibility to promote the development of good character;

Whereas Congress encourages individuals and organizations, especially those that have an interest in the education and training of the young people of the United States, to adopt the elements of character as intrinsic to the well-being of individuals, communities, and society;

Whereas many schools in the United States recognize the need, and have taken steps, to integrate the values of their communities into their teaching activities; and

Whereas the establishment of ''National Character Counts Week'', during which individuals, families, schools, youth organizations, religious institutions, civic groups, and other organizations focus on character education, is of great benefit to the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week beginning October 18, 2009, as ''National Character Counts Week''; and

(2) calls upon the people of the United States and interested groups—

(A) to embrace the elements of character identified by local schools and communities, such as trustworthiness, respect, responsibility, fairness, caring, and citizenship; and

(B) to observe the week with appropriate ceremonies, programs, and activities.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2692. Mr. HARKIN (for himself and Mr. ENZI) proposed an amendment to the bill S. 1793, to amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS.

SA 2693. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1776, to amend title XVIII of the Social Security Act to provide for the update under the Medicare physician fee schedule for years beginning with 2010 and to sunset the application of the sustainable growth rate formula, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2692. Mr. HARKIN (for himself and Mr. ENZI) proposed an amendment to the bill S. 1793, to amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS; as follows:

On page 5, line 14, strike ''In'' and insert ''in''.

On page 7, line 12, add ''and'' at the end.

On page 7, line 24, strike ''(vi)'' and insert ''(C)'' and realign the margin accordingly.

On page 8, line 1, strike ''(g)'' and insert ''(d)''.

On page 26, line 5, insert ''section'' after ''in''.

On page 26, line 6, strike ''(c)(A)'' and insert ''(c)(4)(A)''.

On page 26, line 13, strike ''(c)'' and insert ''(c))''.

On page 31, line 24, strike ''(a)'' and insert ''(1)'' and realign the margin accordingly.

On page 31, line 26, strike ''(b)'' and insert ''(2)'' and realign the margin accordingly.

On page 42, line 13, strike ''subpart'' and insert ''part''.

On page 46, line 24, strike ''subpart'' and insert ''part''.

On page 47, line 10, strike ''subpart'' and insert ''part''.

On page 48, strike lines 1 through 8, and insert the following:

''(a) LIABILITY OF MEDICAL FACILITIES, DESIGNATED OFFICERS, PUBLIC HEALTH OFFICERS, AND GOVERNING ENTITIES.—This part may not be construed to authorize any cause of action for damages or any civil penalty against any medical facility, any designated officer, any other public health officer, or any governing entity of such facility or officer for failure to comply with the duties established in this part.''.

On page 48, line 9, strike ''subpart'' and insert ''part''.

On page 48, line 13, strike ''subpart'' and insert ''part''.

On page 48, line 20, strike ''subpart'' and insert ''part''.

On page 49, line 18, strike ''subpart'' and insert ''part''.

On page 49, line 23, strike ''subpart'' and insert ''part''.

On page 50, line 1, strike ''subpart'' and insert ''part''.

On page 50, line 2, strike ''subpart'' and insert ''part''.

On page 50, line 5, strike ''subpart'' and insert ''part''.

SA 2693. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1776, to amend title XVIII of the Social Security Act to provide for the update under the Medicare physician fee schedule for years beginning with 2010 and to sunset the application of the sustainable growth rate formula, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. REDUCTION IN TARP FUNDS TO OFFSET THE COSTS OF THE PAYMENT UPDATE FOR MEDICARE PHYSICIANS' SERVICES.

Paragraph (3) of section 115(a) of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5225) is amended by striking ''$1,244,000,000'' and inserting ''$251,244,000,000''.

RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT OF 2009

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calender No. 182, S. 1793.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1793) to amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS.

There being no objection, the Senate proceeded to consider the bill.

Mr. HARKIN. Mr. President, today marks an important milestone in our ongoing national effort to combat HIV and AIDS. Twenty-eight years ago, the Centers for Disease Control and Prevention issued its first warning about the disease we now know as AIDS. Today, we are approving the fourth extension of the Ryan White CARE Act, comprehensive legislation first enacted

in 1990 for the prevention and treatment of HIV and AIDS.

In those early days, the Nation failed on all levels to fully recognize the dangers posed by this disease. Its victims suffered in silence and stigma. Shamefully, those who had the power to help did nothing.

Then, belatedly, in the mid 1990s, a young boy's courage opened the Nation's eyes to the tragedy of AIDS. A disease that had seemed distant was suddenly a potential threat to any of us. We realized that it is a deadly virus that does not discriminate based on color, religion, political affiliation, or income status. I have no doubt that Ryan White would be proud of the bipartisan effort that, after months of negotiation and compromise, has produced the bill before us today.

In 1987, bipartisan legislation was first introduced calling for a comprehensive national strategy focusing on education, prevention, and research to halt the spread of AIDS. We summoned government, the public health community, and the media all to do their part raise public awareness and combat the AIDS epidemic across America.

Yet, today, more than two decades later, the battle continues. We mourn the more than 500,000 Americans who have been lost to the AIDS virus. However, we take heart from the fact that AIDS is no longer a death sentence. Through testing and treatment, people are living long, full, productive lives with HIV. We are identifying victims earlier in the progression of the disease, and keeping them healthier longer.

However, we still have a long way to go. Many who live with HIV and AIDS do not have insurance to pay for costly treatments. As a result, heavy demands are placed on community-based organizations, as well as on State and local governments. For most of these citizens, the Ryan White CARE Act continues to provide the only means to obtain the care and treatment they need.

The Ryan White CARE Act began as an emergency response to the HIV/AIDS crisis in urban America, but today it has been broadened into a national strategy to provide care and support for people living with HIV and AIDS anywhere in America.

This bill builds on a consensus among States, cities, community-based organizations, hospitals and health providers, and persons living with HIV and AIDS their families and advocates: It maintains access to life-saving medications, quality health care, and support services for persons living with HIV and AIDS who have come to depend on publicly funded systems, it extends this system of quality care to persons with HIV and AIDS who have faced long waiting lists for medications and severe limits on their access to specialty health care; it bolsters governmental and community-based institutions charged with providing this care, all of whom face growing case loads and the greater challenges of an evolving population of persons with HIV/AIDS; it balances the needs of high-prevalence cities and States with those facing rapidly growing epidemics; it assures those who have been relying on their local system of care that it will continue to be there for them; and it reassures persons seeking tests for HIV that comprehensive care and support will be available.

At its best, the United States has the finest HIV/AIDS care system, truly the gold standard for the rest of the world to emulate. Our goal in this legislation is to make the U.S. HIV/AIDS care system also the fairest in the world, with equal access for all, high quality standards, and guaranteed continuity of care—regardless of geographical location.

This bill is a great example of the good and important things we can accomplish in this body when we work together with bipartisanship, goodwill, and a spirit of compromise. This is also complex legislation, and all our committee staff members, Democratic and Republican alike, deserve great credit for their expertise, and for their diligence in bringing us to this day. I want to recognize Connie Garner and Jenelle Krishnamoorthy from my staff, Hayden Rhudy from Senator ENZI's staff, Tamar Magarik Haro from Senator DODD's staff, and Evan Feinberg from Senator COBURN's staff for their dedication and hard work on this legislation.

To say the least, this legislation is extremely important to Americans living with HIV and AIDS. For them, it is a lifeline. It offers hope for an active, productive, dignified life. This legislation shows America at its very best: compassionate, generous, extending a hand up to those in great need. Mr. President, I thank my colleagues for coming together to support this important, bipartisan bill.

Mr. BROWN. Mr. President, this is the Ryan White HIV Act, which is particularly important legislation. I join millions of people in the country in supporting it.

I ask unanimous consent that a Harkin amendment, which is at the desk, be agreed to; that the bill, as amended, be read the third time and passed; that the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements related to the bill be printed in the RECORD.

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

The amendment (No. 2692) was agreed to, as follows:

AMENDMENT NO. 2692

On page 5, line 14, strike ''In'' and insert ''in''.

On page 7, line 12, add ''and'' at the end.

On page 7, line 24, strike ''(vi)'' and insert ''(C)'' and realign the margin accordingly.

On page 8, line 1, strike ''(g)'' and insert ''(d)''.

On page 26, line 5, insert ''section'' after ''in''.

On page 26, line 6, strike ''(c)(A)'' and insert ''(c)(4)(A)''.

On page 26, line 13, strike ''(c)'' and insert ''(c))''.

On page 31, line 24, strike ''(a)'' and insert ''(1)'' and realign the margin accordingly.

On page 31, line 26, strike ''(b)'' and insert ''(2)'' and realign the margin accordingly.

On page 42, line 13, strike ''subpart'' and insert ''part''.

On page 46, line 24, strike ''subpart'' and insert ''part''.

On page 47, line 10, strike ''subpart'' and insert ''part''.

On page 48, strike lines 1 through 8, and insert the following:

''(a) LIABILITY OF MEDICAL FACILITIES, DESIGNATED OFFICERS, PUBLIC HEALTH OFFICERS, AND GOVERNING ENTITIES.—This part may not be construed to authorize any cause of action for damages or any civil penalty against any medical facility, any designated officer, any other public health officer, or any governing entity of such facility or officer for failure to comply with the duties established in this part.''.

On page 48, line 9, strike ''subpart'' and insert ''part''.

On page 48, line 13, strike ''subpart'' and insert ''part''.

On page 48, line 20, strike ''subpart'' and insert ''part''.

On page 49, line 18, strike ''subpart'' and insert ''part''.

On page 49, line 23, strike ''subpart'' and insert ''part''.

On page 50, line 1, strike ''**SUBPART**'' and insert ''**PART**''.

On page 50, line 2, strike ''subpart'' and insert ''part''.

On page 50, line 5, strike ''subpart'' and insert ''part''.

The bill (S. 1793) was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S. 1793

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES.

(a) SHORT TITLE.—This Act may be cited as the ''Ryan White HIV/AIDS Treatment Extension Act of 2009''.

(b) REFERENCES.—Except as otherwise specified, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2. REAUTHORIZATION OF HIV HEALTH CARE SERVICES PROGRAM.

(a) ELIMINATION OF SUNSET PROVISION.—

(1) IN GENERAL.—The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109–415; 120 Stat. 2767) is amended by striking section 703.

(2) EFFECTIVE DATE.—Paragraph (1) shall take effect as if enacted on September 30, 2009.

(3) CONTINGENCY PROVISIONS.—Notwithstanding section 703 of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109–415; 120 Stat. 2767) and section 139 of the Continuing Appropriations Resolution, 2010—

(A) the provisions of title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.), as in effect on September 30, 2009, are hereby revived; and

(B) the amendments made by this Act to title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.) shall apply to such title as so revived and shall take effect as if enacted on September 30, 2009.

(b) PART A GRANTS.—Section 2610(a) (42 U.S.C. 300ff–20(a)) is amended by striking ''and $649,500,000 for fiscal year 2009'' and inserting ''$649,500,000 for fiscal year 2009,

$681,975,000 for fiscal year 2010, $716,074,000 for fiscal year 2011, $751,877,000 for fiscal year 2012, and $789,471,000 for fiscal year 2013''.

(c) PART B GRANTS.—Section 2623(a) (42 U.S.C. 300ff–32(a)) is amended by striking ''and $1,285,200,000 for fiscal year 2009'' and inserting ''$1,285,200,000 for fiscal year 2009, $1,349,460,000 for fiscal year 2010, $1,416,933,000 for fiscal year 2011, $1,487,780,000 for fiscal year 2012, and $1,562,169,000 for fiscal year 2013''.

(d) PART C GRANTS.—Section 2655 (42 U.S.C. 300ff–55) is amended by striking ''and $235,100,000 for fiscal year 2009'' and inserting ''$235,100,000 for fiscal year 2009, $246,855,000 for fiscal year 2010, $259,198,000 for fiscal year 2011, $272,158,000 for fiscal year 2012, and $285,766,000 for fiscal year 2013''.

(e) PART D GRANTS.—Section 2671(i) (42 U.S.C. 300ff–71(i)) is amended by inserting before the period at the end '', $75,390,000 for fiscal year 2010, $79,160,000 for fiscal year 2011, $83,117,000 for fiscal year 2012, and $87,273,000 for fiscal year 2013''.

(f) DEMONSTRATION AND TRAINING GRANTS UNDER PART F.—

(1) HIV/AIDS COMMUNITIES, SCHOOLS, AND CENTERS.—Section 2692(c) (42 U.S.C. 300ff–111(c)) is amended—

(A) in paragraph (1)—

(i) by striking ''is authorized'' and inserting ''are authorized''; and

(ii) by inserting before the period at the end '', $36,535,000 for fiscal year 2010, $38,257,000 for fiscal year 2011, $40,170,000 for fiscal year 2012, and $42,178,000 for fiscal year 2013'' ; and

(B) in paragraph (2)—

(i) by striking ''is authorized'' and inserting ''are authorized''; and

(ii) by inserting before the period at the end '', $13,650,000 for fiscal year 2010, $14,333,000 for fiscal year 2011, $15,049,000 for fiscal year 2012, and $15,802,000 for fiscal year 2013''.

(2) MINORITY AIDS INITIATIVE.—Section 2693 (42 U.S.C. 300ff–121) is amended—

(A) in subsection (a), by striking ''and $139,100,000 for fiscal year 2009.'' and inserting ''$139,100,000 for fiscal year 2009, $146,055,000 for fiscal year 2010, $153,358,000 for fiscal year 2011, $161,026,000 for fiscal year 2012, and $169,077,000 for fiscal year 2013. The Secretary shall develop a formula for the awarding of grants under subsections (b)(1)(A) and (b)(1)(B) that ensures that funding is provided based on the distribution of populations disproportionately impacted by HIV/AIDS.'';

(B) in subsection (b)(2)—

(i) in subparagraph (A)—

(I) in the matter preceding clause (i), by striking ''competitive,''; and

(II) by adding at the end the following:

''(iv) For fiscal year 2010, $46,738,000.

''(v) For fiscal year 2011, $49,075,000.

''(vi) For fiscal year 2012, $51,528,000.

''(vii) For fiscal year 2013, $54,105,000.'';

(ii) in subparagraph (B)—

(I) in the matter preceding clause (i), by striking ''competitive''; and

(II) by adding at the end the following:

''(iv) For fiscal year 2010, $8,763,000.

''(v) For fiscal year 2011, $9,202,000.

''(vi) For fiscal year 2012, $9,662,000.

''(vii) For fiscal year 2013, $10,145,000.'';

(iii) in subparagraph (C), by adding at the end the following:

''(iv) For fiscal year 2010, $61,343,000.

''(v) For fiscal year 2011, $64,410,000.

''(vi) For fiscal year 2012, $67,631,000.

''(vii) For fiscal year 2013, $71,012,000.'';

(iv) in subparagraph (D), by striking ''$18,500,000'' and all that follows through the period and inserting the following: ''the following, as applicable:

''(i) For fiscal year 2010, $20,448,000.

''(ii) For fiscal year 2011, $21,470,000.

''(iii) For fiscal year 2012, $22,543,000.

''(iv) For fiscal year 2013, $23,671,000.''; and

(v) in subparagraph (E), by striking ''$8,500,000'' and all that follows through the period and inserting the following: ''the following, as applicable:

''(i) For fiscal year 2010, $8,763,000.

''(ii) For fiscal year 2011, $9,201,000.

''(iii) For fiscal year 2012, $9,662,000.

''(iv) For fiscal year 2013, $10,144,000.''; and

(C) by adding at the end the following:

''(d) SYNCHRONIZATION OF MINORITY AIDS INITIATIVE.—For fiscal year 2010 and each subsequent fiscal year, the Secretary shall incorporate and synchronize the schedule of application submissions and funding availability under this section with the schedule of application submissions and funding availability under the corresponding provisions of this title XXVI as follows:

''(1) The schedule for carrying out subsection (b)(1)(A) shall be the same as the schedule applicable to emergency assistance under part A.

''(2) The schedule for carrying out subsection (b)(1)(B) shall be the same as the schedule applicable to care grants under part B.

''(3) The schedule for carrying out subsection (b)(1)(C) shall be the same as the schedule applicable to grants for early intervention services under part C.

''(4) The schedule for carrying out subsection (b)(1)(D) shall be the same as the schedule applicable to grants for services through projects for HIV-related care under part D.

''(5) The schedule for carrying out subsection (b)(1)(E) shall be the same as the schedule applicable to grants and contracts for activities through education and training centers under section 2692.''.

(3) HHS REPORT.—Not later than 6 months after the publication of the Government Accountability Office Report on the Minority Aids Initiative described in section 2686, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a Departmental plan for using funding under section 2693 of the Public Health Service Act (42 U.S.C. 300ff–93) in all relevant agencies to build capacity, taking into consideration the best practices included in such Report.

(g) GAO REPORT.—Section 2686 (42 U.S.C. 300ff–86) is amended to read as follows:

''SEC. 2686. GAO REPORT.

''The Comptroller General of the Government Accountability Office shall, not less than 1 year after the date of enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, submit to the appropriate committees of Congress a report describing Minority AIDS Initiative activities across the Department of Health and Human Services, including programs under this title and programs at the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and other departmental agencies. Such report shall include a history of program activities within each relevant agency and a description of activities conducted, people served and types of grantees funded, and shall collect and describe best practices in community outreach and capacity-building of community based organizations serving the communities that are disproportionately affected by HIV/AIDS.''.

SEC. 3. EXTENDED EXEMPTION PERIOD FOR NAMES-BASED REPORTING.

(a) PART A GRANTS.—Section 2603(a)(3) (42 U.S.C. 300ff–13(a)(3)) is amended—

(1) in subparagraph (C)—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by striking ''2009'' and inserting ''2012''; and

(ii) in subclause (II), by striking ''or 2009'' and inserting ''or a subsequent fiscal year through fiscal year 2012'';

(B) in clause (iv), by striking ''2010'' and inserting ''2012'';

(C) in clause (v), by inserting ''or a subsequent fiscal year'' after ''2009'';

(D) in clause (vi)(II), by inserting after ''5 percent'' the following: ''for fiscal years before fiscal year 2012 (and 6 percent for fiscal year 2012)'';

(E) in clause (ix)(II)—

(i) by striking ''2010'' and inserting ''2013''; and

(ii) by striking ''2009'' and inserting ''2012''; and

(F) by adding at the end the following:

''(xi) FUTURE FISCAL YEARS.—For fiscal years beginning with fiscal year 2013, determinations under this paragraph shall be based only on living names-based cases of HIV/AIDS with respect to the area involved.''; and

(2) in subparagraph (D)—

(A) in clause (i)—

(i) in the matter preceding subclause (I), by striking ''2009'' and inserting ''2012''; and

(ii) in subclause (II), by striking ''and 2009'' and inserting ''through 2012''; and

(B) in clause (ii), by striking ''2009'' and inserting ''2012''.

(b) PART B GRANTS.—Section 2618(a)(2) (42 U.S.C. 300ff–28(a)(2)) is amended—

(1) in subparagraph (D)—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by striking ''2009'' and inserting ''2012''; and

(ii) in subclause (II), by striking ''or 2009'' and inserting ''or a subsequent fiscal year through fiscal year 2012'';

(B) in clause (iv), by striking ''2010'' and inserting ''2012'';

(C) in clause (v), by inserting ''or a subsequent fiscal year'' after ''2009'';

(D) in clause (vi)(II), by inserting after ''5 percent'' the following: ''for fiscal years before fiscal year 2012 (and 6 percent for fiscal year 2012)'';

(E) in clause (viii)(II)—

(i) by striking ''2010'' and inserting ''2013''; and

(ii) by striking ''2009'' and inserting ''2012''; and

(F) by adding at the end the following:

''(x) FUTURE FISCAL YEARS.—For fiscal years beginning with fiscal year 2013, determinations under this paragraph shall be based only on living names-based cases of HIV/AIDS with respect to the State involved.''; and

(2) in subparagraph (E), by striking ''2009'' each place it appears and inserting ''2012''.

SEC. 4. EXTENSION OF TRANSITIONAL GRANT AREA STATUS.

(a) ELIGIBILITY.—Section 2609 (42 U.S.C. 300ff–19) is amended—

(1) in subsection (c)(1)—

(A) in the heading, by striking ''2007'' and inserting ''2011''; and

(B) by striking ''2007'' each place it appears and inserting ''2011''; and

(C) by striking ''2006'' and inserting ''2010'';

(2) in subsection (c)(2)—

(A) in subparagraph (A)(ii), by striking ''to have a'' and inserting ''subject to subparagraphs (B) and (C), to have a'';

(B) by redesignating subparagraph (B) as subparagraph (C);

(C) by inserting after subparagraph (A) the following:

''(B) PERMITTING MARGIN OF ERROR APPLICABLE TO CERTAIN METROPOLITAN AREAS.—In applying subparagraph (A)(ii) for a fiscal year after fiscal year 2008, in the case of a metropolitan area that has a cumulative total of at least 1,400 (and fewer than 1,500) living cases of AIDS as of December 31 of the most recent calendar year for which such data is

available, such area shall be treated as having met the criteria of such subparagraph if not more than 5 percent of the total from grants awarded to such area under this part is unobligated as of the end of the most recent fiscal year for which such data is available.''; and

(D) in subparagraph (C), as so redesignated, by striking ''Subparagraph (A) does not apply'' and inserting ''Subparagraphs (A) and (B) do not apply''; and

(3) in subsection (d)(1)(B), strike ''2009'' and insert ''2013''.

(b) TRANSFER OF AMOUNTS DUE TO CHANGE IN STATUS AS TRANSITIONAL AREA.—Subparagraph (B) of section 2610(c)(2) (42 U.S.C. 300ff–20(c)(2)) is amended—

(1) by striking ''(B)'' and inserting ''(B)(i) subject to clause (ii),'';

(2) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(ii) for each of fiscal years 2010 through 2013, notwithstanding subsection (a)—

''(I) there shall be transferred to the State containing the metropolitan area, for purposes described in section 2612(a), an amount (which shall not be taken into account in applying section 2618(a)(2)(H)) equal to—

''(aa) for the first fiscal year of the metropolitan area not being a transitional area, 75 percent of the amount described in subparagraph (A)(i) for such area;

''(bb) for the second fiscal year of the metropolitan area not being a transitional area, 50 percent of such amount; and

''(cc) for the third fiscal year of the metropolitan area not being a transitional area, 25 percent of such amount; and

''(II) there shall be transferred and made available for grants pursuant to section 2618(a)(1) for the fiscal year, in addition to amounts available for such grants under section 2623, an amount equal to the total amount of the reduction for such fiscal year under subparagraph (A), less the amount transferred for such fiscal year under subclause (I).''.

SEC. 5. HOLD HARMLESS.

(a) PART A GRANTS.—Section 2603(a)(4) (42 U.S.C. 300ff–13(a)(4)) is amended—

(1) in the matter preceding clause (i) in subparagraph (A)—

(A) by striking ''2006'' and inserting ''2009''; and

(B) by striking ''2007 through 2009'' and inserting ''2010 through 2013'';

(2) by striking clauses (i) and (ii) in subparagraph (A) and inserting the following:

''(i) For fiscal year 2010, an amount equal to 95 percent of the sum of the amount of the grant made pursuant to paragraph (3) and this paragraph for fiscal year 2009.

''(ii) For each of the fiscal years 2011 and 2012, an amount equal to 100 percent of the amount of the grant made pursuant to paragraph (3) and this paragraph for fiscal year 2010.

''(iii) For fiscal year 2013, an amount equal to 92.5 percent of the amount of the grant made pursuant to paragraph (3) and this paragraph for fiscal year 2012.''; and

(3) in subparagraph (C), by striking ''2009'' and inserting ''2013''.

(b) PART B GRANTS.—Section 2618(a)(2)(H) (42 U.S.C. 300ff–28(a)(2)(H)) is amended—

(1) in clause (i)(I)—

(A) by striking ''2007'' and inserting ''2010''; and

(B) by striking ''2006'' and inserting ''2009'';

(2) by striking clause (ii) and redesignating clause (iii) as clause (ii);

(3) in clause (ii), as so redesignated—

(A) in the heading, by striking ''2008 AND 2009'' and inserting ''2011 AND 2012'';

(B) by striking ''2008 and 2009'' and inserting ''2011 and 2012''; and

(C) by striking ''2007'' and inserting ''2010'';

(4) by inserting after clause (ii), as so redesignated, the following new clause:

''(iii) FISCAL YEAR 2013.—For fiscal year 2013, the Secretary shall ensure that the total for a State of the grant pursuant to paragraph (1) and the grant pursuant to subparagraph (F) is not less than 92.5 percent of such total for the State for fiscal year 2012.''; and

(5) in clause (v), by striking ''2009'' and inserting ''2013''.

(c) TECHNICAL CORRECTIONS.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(1) in subparagraphs (A)(i) and (H) of section 2618(a)(2), by striking the term ''subparagraph (G)'' each place it appears and inserting ''subparagraph (F)'';

(2) in sections 2620(a)(2), 2622(c)(1), and 2622(c)(4)(A), by striking ''2618(a)(2)(G)(i)'' and inserting ''2618(a)(2)(F)(i)'';

(3) in sections 2622(a) and 2623(b)(2)(A), by striking ''2618(a)(2)(G)'' and inserting ''2618(a)(2)(F)''; and

(4) in section 2622(b), by striking ''2618(a)(2)(G)(ii)'' and inserting ''2618(a)(2)(F)(ii)''.

SEC. 6. AMENDMENTS TO THE GENERAL GRANT PROVISIONS.

(a) ADMINISTRATION AND PLANNING COUNCIL.—Section 2602(b)(4) (42 U.S.C. 300ff–12(b)(4)) is amended—

(1) in subparagraph (A), by inserting '', as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status'' after ''HIV/AIDS'';

(2) in subparagraph (B)—

(A) in clause (i), by striking ''and'' at the end after the semicolon;

(B) in clause (ii), by inserting ''and'' after the semicolon; and

(C) by adding at the end the following:

''(iii) individuals with HIV/AIDS who do not know their HIV status;''; and

(3) in subparagraph (D)—

(A) in clause (ii), by striking ''and'' at the end after the semicolon;

(B) in clause (iii), by inserting ''and'' after the semicolon; and

(C) by adding at the end the following:

''(iv) includes a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in section 2604, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities;''.

(b) TYPE AND DISTRIBUTION OF GRANTS.—Section 2603(b) (42 U.S.C. 300ff–13(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (G), by striking ''and'' at the end after the semicolon;

(B) in subparagraph (H), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(I) demonstrates success in identifying individuals with HIV/AIDS as described in clauses (i) through (iii) of paragraph (2)(A).''; and

(2) in paragraph (2)(A), by striking the period and inserting: '', and demonstrated success in identifying individuals with HIV/AIDS who do not know their HIV status and making them aware of such status counting one-third. In making such determination, the Secretary shall consider—

''(i) the number of individuals who have been tested for HIV/AIDS;

''(ii) of those individuals described in clause (i), the number of individuals who tested for HIV/AIDS who are made aware of their status, including the number who test positive; and

''(iii) of those individuals described in clause (ii), the number who have been referred to appropriate treatment and care.''.

(c) APPLICATION.—Section 2605(b)(1) (42 U.S.C. 300ff–15(b)(1)) is amended by inserting '', including the identification of individuals with HIV/AIDS as described in clauses (i) through (iii) of section 2603(b)(2)(A)'' before the semicolon at the end.

SEC. 7. INCREASE IN ADJUSTMENT FOR NAMES-BASED REPORTING.

(a) PART A GRANTS.—

(1) FORMULA GRANTS.—Section 2603(a)(3)(C)(vi) (42 U.S.C. 300ff–13(a)(3)(C)(vi)) is amended by adding at the end the following:

''(III) INCREASED ADJUSTMENT FOR CERTAIN AREAS PREVIOUSLY USING CODE-BASED REPORTING.—For purposes of this subparagraph for each of fiscal years 2010 through 2012, the Secretary shall deem the applicable number of living cases of HIV/AIDS in an area that were reported to and confirmed by the Centers for Disease Control and Prevention to be 3 percent higher than the actual number if—

''(aa) for fiscal year 2007, such area was a transitional area;

''(bb) fiscal year 2007 was the first year in which the count of living non-AIDS cases of HIV in such area, for purposes of this section, was based on a names-based reporting system; and

''(cc) the amount of funding that such area received under this part for fiscal year 2007 was less than 70 percent of the amount of funding (exclusive of funds that were identified as being for purposes of the Minority AIDS Initiative) that such area received under such part for fiscal year 2006.''.

(2) SUPPLEMENTAL GRANTS.—Section 2603(b)(2) (42 U.S.C. 300ff–13(b)(2)) is amended by adding at the end the following:

''(D) INCREASED ADJUSTMENT FOR CERTAIN AREAS PREVIOUSLY USING CODE-BASED REPORTING.—For purposes of this subsection for each of fiscal years 2010 through 2012, the Secretary shall deem the applicable number of living cases of HIV/AIDS in an area that were reported to and confirmed by the Centers for Disease Control and Prevention to be 3 percent higher than the actual number if the conditions described in items (aa) through (cc) of subsection (a)(3)(C)(vi)(III) are all satisfied.''.

(b) PART B GRANTS.—Section 2618(a)(2)(D)(vi) (42 U.S.C. 300ff–28(a)(2)(D)(vi)) is amended by adding at the end the following:

''(III) INCREASED ADJUSTMENT FOR CERTAIN STATES PREVIOUSLY USING CODE-BASED REPORTING.—For purposes of this subparagraph for each of fiscal years 2010 through 2012, the Secretary shall deem the applicable number of living cases of HIV/AIDS in a State that were reported to and confirmed by the Centers for Disease Control and Prevention to be 3 percent higher than the actual number if—

''(aa) there is an area in such State that satisfies all of the conditions described in items (aa) through (cc) of section 2603(a)(3)(C)(vi)(III); or

''(bb)(AA) fiscal year 2007 was the first year in which the count of living non-AIDS cases of HIV in such area, for purposes of this part, was based on a names-based reporting system; and

''(BB) the amount of funding that such State received under this part for fiscal year 2007 was less than 70 percent of the amount of funding that such State received under such part for fiscal year 2006.''.

SEC. 8. TREATMENT OF UNOBLIGATED FUNDS.

(a) ELIGIBILITY FOR SUPPLEMENTAL GRANTS.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(1) in section 2603(b)(1)(H) (42 U.S.C. 300ff–13(b)(1)(H)), by striking ''2 percent'' and inserting ''5 percent''; and

(2) in section 2620(a)(2) (42 U.S.C. 300ff–29a(a)(2)), by striking ''2 percent'' and inserting ''5 percent''.

(b) CORRESPONDING REDUCTION IN FUTURE GRANT.—

(1) IN GENERAL.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(A) in section 2603(c)(3)(D)(i)(42 U.S.C. 300ff–13(c)(3)(D)(i)), in the matter following subclause (II), by striking ''2 percent'' and inserting ''5 percent''; and

(B) in section 2622(c)(4)(A) (42 U.S.C. 300ff–31a(c)(4)(A)), in the matter following clause (ii), by striking ''2 percent'' and inserting ''5 percent''.

(2) AUTHORITY REGARDING ADMINISTRATION OF PROVISION.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(A) in section 2603(c) (42 U.S.C. 300ff–13(c)), by adding at the end the following:

''(4) AUTHORITY REGARDING ADMINISTRATION OF PROVISIONS.—In administering paragraphs (2) and (3) with respect to the unobligated balance of an eligible area, the Secretary may elect to reduce the amount of future grants to the area under subsection (a) or (b), as applicable, by the amount of any such unobligated balance in lieu of cancelling such amount as provided for in paragraph (2) or (3)(A). In such case, the Secretary may permit the area to use such unobligated balance for purposes of any such future grant. An amount equal to such reduction shall be available for use as additional amounts for grants pursuant to subsection (b), subject to subsection (a)(4) and section 2610(d)(2). Nothing in this paragraph shall be construed to affect the authority of the Secretary under paragraphs (2) and (3), including the authority to grant waivers under paragraph (3)(A). The reduction in future grants authorized under this paragraph shall be notwithstanding the penalty required under paragraph (3)(D) with respect to unobligated funds.'';

(B) in section 2622 (42 U.S.C. 300ff–31a), by adding at the end the following:

''(e) AUTHORITY REGARDING ADMINISTRATION OF PROVISIONS.—In administering subsections (b) and (c) with respect to the unobligated balance of a State, the Secretary may elect to reduce the amount of future grants to the State under section 2618, 2620, or 2621, as applicable, by the amount of any such unobligated balance in lieu of cancelling such amount as provided for in subsection (b) or (c)(1). In such case, the Secretary may permit the State to use such unobligated balance for purposes of any such future grant. An amount equal to such reduction shall be available for use as additional amounts for grants pursuant to section 2620, subject to section 2618(a)(2)(H). Nothing in this paragraph shall be construed to affect the authority of the Secretary under subsections (b) and (c), including the authority to grant waivers under subsection (c)(1). The reduction in future grants authorized under this subsection shall be notwithstanding the penalty required under subsection (c)(4) with respect to unobligated funds.'';

(C) in section 2603(b)(1)(H) (42 U.S.C. 300ff–13(b)(1)(H)), by striking ''canceled'' and inserting ''canceled, offset under subsection (c)(4),''; and

(D) in section 2620(a)(2) (42 U.S.C. 300ff–29a(a)(2)), by striking ''canceled'' and inserting ''canceled, offset under section 2622(e),''.

(c) CONSIDERATION OF WAIVER AMOUNTS IN DETERMINING UNOBLIGATED BALANCES.—

(1) PART A GRANTS.—Section 2603(c)(3)(D)(i)(I) (42 U.S.C. 300ff–14(c)(3)(D)(i)(I)) is amended by inserting after ''unobligated balance'' the following: ''(less any amount of such balance that is the subject of a waiver of cancellation under subparagraph (A))''.

(2) PART B GRANTS.—Section 2622(c)(4)(A)(i) (42 U.S.C. 300ff—31a(c)(4)(A)(i)) is amended by inserting after ''unobligated balance'' the following: ''(less any amount of such balance that is the subject of a waiver of cancellation under paragraph (1))''.

SEC. 9. APPLICATIONS BY STATES.

Section 2617(b) (42 U.S.C. Section 300ff–27(b)) is amended—

(1) in paragraph (6), by striking ''and'' at the end;

(2) in paragraph (7), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(8) a comprehensive plan—

''(A) containing an identification of individuals with HIV/AIDS as described in clauses (i) through (iii) of section 2603(b)(2)(A) and the strategy required under section 2602(b)(4)(D)(iv);

''(B) describing the estimated number of individuals within the State with HIV/AIDS who do not know their status;

''(C) describing activities undertaken by the State to find the individuals described in subparagraph (A) and to make such individuals aware of their status;

''(D) describing the manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV/AIDS; and

''(E) describing efforts to remove legal barriers, including State laws and regulations, to routine testing.''.

SEC. 10. ADAP REBATE FUNDS.

(a) USE OF UNOBLIGATED FUNDS.—Section 2622(d) (42 U.S.C. 300ff–31a(d)) is amended by adding at the end the following: ''If an expenditure of ADAP rebate funds would trigger a penalty under this section or a higher penalty than would otherwise have applied, the State may request that for purposes of this section, the Secretary deem the State's unobligated balance to be reduced by the amount of rebate funds in the proposed expenditure. Notwithstanding 2618(a)(2)(F), any unobligated amount under section 2618(a)(2)(F)(ii)(V) that is returned to the Secretary for reallocation shall be used by the Secretary for—

''(1) the ADAP supplemental program if the Secretary determines appropriate; or

''(2) for additional amounts for grants pursuant to section 2620.''.

(b) TECHNICAL CORRECTION.—Subclause (V) of section 2618(a)(2)(F)(ii) (42 U.S.C. 300ff–28(a)(2)(F)(ii)) is amended by striking '', subject to subclause (VI)''.

SEC. 11. APPLICATION TO PRIMARY CARE SERVICES.

(a) IN GENERAL.—Section 2671 (42 U.S.C. 300ff–71), as amended, is amended—

(1) by redesignating subsection (i) as subsection (j);

(2) in subsection (g), by striking ''subsection (i)'' and inserting ''subsection (j)''; and

(3) by inserting after subsection (h) the following:

''(i) APPLICATION TO PRIMARY CARE SERVICES.—Nothing in this part shall be construed as requiring funds under this part to be used for primary care services when payments are available for such services from other sources (including under titles XVIII, XIX, and XXI of the Social Security Act).''.

(b) PROVISION OF CARE THROUGH MEMORANDUM OF UNDERSTANDING.—Section 2671(a) (42 U.S.C. 300ff–71(a)) is amended by striking ''(directly or through contracts)'' and inserting ''(directly or through contracts or memoranda of understanding)''.

SEC. 12. NATIONAL HIV/AIDS TESTING GOAL.

Part E of title XXVI (42 U.S.C. 300ff–81 et seq.) is amended—

(1) by redesignating section 2688 as section 2689; and

(2) by inserting after section 2687 the following:

''SEC. 2688. NATIONAL HIV/AIDS TESTING GOAL.

''(a) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a national HIV/AIDS testing goal of 5,000,000 tests for HIV/AIDS annually through federally-supported HIV/AIDS prevention, treatment, and care programs, including programs under this title and other programs administered by the Centers for Disease Control and Prevention.

''(b) ANNUAL REPORT.—Not later than January 1, 2011, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to Congress a report describing, with regard to the preceding 12-month reporting period—

''(1) whether the testing goal described in subsection (a) has been met;

''(2) the total number of individuals tested through federally-supported and other HIV/AIDS prevention, treatment, and care programs in each State;

''(3) the number of individuals who—

''(A) prior to such 12-month period, were unaware of their HIV status; and

''(B) through federally-supported and other HIV/AIDS prevention, treatment, and care programs, were diagnosed and referred into treatment and care during such period;

''(4) any barriers, including State laws and regulations, that the Secretary determines to be a barrier to meeting the testing goal described in subsection (a);

''(5) the amount of funding the Secretary determines necessary to meet the annual testing goal in the following 12 months and the amount of Federal funding expended to meet the testing goal in the prior 12-month period; and

''(6) the most cost-effective strategies for identifying and diagnosing individuals who were unaware of their HIV status, including voluntary testing with pre-test counseling, routine screening including opt-out testing, partner counseling and referral services, and mass media campaigns.

''(c) REVIEW OF PROGRAM EFFECTIVENESS.—Not later than 1 year after the date of enactment of this section, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall submit a report to Congress based on a comprehensive review of each of the programs and activities conducted by the Centers for Disease Control and Prevention as part of the Domestic HIV/AIDS Prevention Activities, including the following:

''(1) The amount of funding provided for each program or activity.

''(2) The primary purpose of each program or activity.

''(3) The annual goals for each program or activity.

''(4) The relative effectiveness of each program or activity with relation to the other programs and activities conducted by the Centers for Disease Control and Prevention, based on the—

''(A) number of previously undiagnosed individuals with HIV/AIDS made aware of their status and referred into the appropriate treatment;

''(B) amount of funding provided for each program or activity compared to the number of undiagnosed individuals with HIV/AIDS made aware of their status;

''(C) program's contribution to the National HIV/AIDS testing goal; and

''(D) progress made toward the goals described in paragraph (3).

''(5) Recommendations if any to Congress on ways to allocate funding for domestic HIV/AIDS prevention activities and programs in order to achieve the National HIV/AIDS testing goal.

''(d) COORDINATION WITH OTHER FEDERAL ACTIVITIES.—In pursuing the National HIV/AIDS testing goal, the Secretary, where appropriate, shall consider and coordinate with other national strategies conducted by the Federal Government to address HIV/AIDS.''.

SEC. 13. NOTIFICATION OF POSSIBLE EXPOSURE TO INFECTIOUS DISEASES.

Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended by adding at the end the following:

''PART G—NOTIFICATION OF POSSIBLE EXPOSURE TO INFECTIOUS DISEASES

''SEC. 2695. INFECTIOUS DISEASES AND CIRCUMSTANCES RELEVANT TO NOTIFICATION REQUIREMENTS.

''(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this part, the Secretary shall complete the development of—

''(1) a list of potentially life-threatening infectious diseases, including emerging infectious diseases, to which emergency response employees may be exposed in responding to emergencies;

''(2) guidelines describing the circumstances in which such employees may be exposed to such diseases, taking into account the conditions under which emergency response is provided; and

''(3) guidelines describing the manner in which medical facilities should make determinations for purposes of section 2695B(d).

''(b) SPECIFICATION OF AIRBORNE INFECTIOUS DISEASES.—The list developed by the Secretary under subsection (a)(1) shall include a specification of those infectious diseases on the list that are routinely transmitted through airborne or aerosolized means.

''(c) DISSEMINATION.—The Secretary shall—

''(1) transmit to State public health officers copies of the list and guidelines developed by the Secretary under subsection (a) with the request that the officers disseminate such copies as appropriate throughout the States; and

''(2) make such copies available to the public.

''SEC. 2695A. ROUTINE NOTIFICATIONS WITH RESPECT TO AIRBORNE INFECTIOUS DISEASES IN VICTIMS ASSISTED.

''(a) ROUTINE NOTIFICATION OF DESIGNATED OFFICER.—

''(1) DETERMINATION BY TREATING FACILITY.—If a victim of an emergency is transported by emergency response employees to a medical facility and the medical facility makes a determination that the victim has an airborne infectious disease, the medical facility shall notify the designated officer of the emergency response employees who transported the victim to the medical facility of the determination.

''(2) DETERMINATION BY FACILITY ASCERTAINING CAUSE OF DEATH.—If a victim of an emergency is transported by emergency response employees to a medical facility and the victim dies at or before reaching the medical facility, the medical facility ascertaining the cause of death shall notify the designated officer of the emergency response employees who transported the victim to the initial medical facility of any determination by the medical facility that the victim had an airborne infectious disease.

''(b) REQUIREMENT OF PROMPT NOTIFICATION.—With respect to a determination described in paragraph (1) or (2) of subsection (a), the notification required in each of such paragraphs shall be made as soon as is practicable, but not later than 48 hours after the determination is made.

''SEC. 2695B. REQUEST FOR NOTIFICATION WITH RESPECT TO VICTIMS ASSISTED.

''(a) INITIATION OF PROCESS BY EMPLOYEE.—If an emergency response employee believes that the employee may have been exposed to an infectious disease by a victim of an emergency who was transported to a medical facility as a result of the emergency, and if the employee attended, treated, assisted, or transported the victim pursuant to the emergency, then the designated officer of the employee shall, upon the request of the employee, carry out the duties described in subsection (b) regarding a determination of whether the employee may have been exposed to an infectious disease by the victim.

''(b) INITIAL DETERMINATION BY DESIGNATED OFFICER.—The duties referred to in subsection (a) are that—

''(1) the designated officer involved collect the facts relating to the circumstances under which, for purposes of subsection (a), the employee involved may have been exposed to an infectious disease; and

''(2) the designated officer evaluate such facts and make a determination of whether, if the victim involved had any infectious disease included on the list issued under paragraph (1) of section 2695(a), the employee would have been exposed to the disease under such facts, as indicated by the guidelines issued under paragraph (2) of such section.

''(c) SUBMISSION OF REQUEST TO MEDICAL FACILITY.—

''(1) IN GENERAL.—If a designated officer makes a determination under subsection (b)(2) that an emergency response employee may have been exposed to an infectious disease, the designated officer shall submit to the medical facility to which the victim involved was transported a request for a response under subsection (d) regarding the victim of the emergency involved.

''(2) FORM OF REQUEST.—A request under paragraph (1) shall be in writing and be signed by the designated officer involved, and shall contain a statement of the facts collected pursuant to subsection (b)(1).

''(d) EVALUATION AND RESPONSE REGARDING REQUEST TO MEDICAL FACILITY.—

''(1) IN GENERAL.—If a medical facility receives a request under subsection (c), the medical facility shall evaluate the facts submitted in the request and make a determination of whether, on the basis of the medical information possessed by the facility regarding the victim involved, the emergency response employee was exposed to an infectious disease included on the list issued under paragraph (1) of section 2695(a), as indicated by the guidelines issued under paragraph (2) of such section.

''(2) NOTIFICATION OF EXPOSURE.—If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has been exposed to an infectious disease, the medical facility shall, in writing, notify the designated officer who submitted the request under subsection (c) of the determination.

''(3) FINDING OF NO EXPOSURE.—If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has not been exposed to an infectious disease, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the determination.

''(4) INSUFFICIENT INFORMATION.—

''(A) If a medical facility finds in evaluating facts for purposes of paragraph (1) that the facts are insufficient to make the determination described in such paragraph, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of the facts.

''(B)(i) If a medical facility finds in making a determination under paragraph (1) that the facility possesses no information on whether the victim involved has an infectious disease included on the list under section 2695(a), the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of such medical information.

''(ii) If after making a response under clause (i) a medical facility determines that the victim involved has an infectious disease, the medical facility shall make the determination described in paragraph (1) and provide the applicable response specified in this subsection.

''(e) TIME FOR MAKING RESPONSE.—After receiving a request under subsection (c) (including any such request resubmitted under subsection (g)(2)), a medical facility shall make the applicable response specified in subsection (d) as soon as is practicable, but not later than 48 hours after receiving the request.

''(f) DEATH OF VICTIM OF EMERGENCY.—

''(1) FACILITY ASCERTAINING CAUSE OF DEATH.—If a victim described in subsection (a) dies at or before reaching the medical facility involved, and the medical facility receives a request under subsection (c), the medical facility shall provide a copy of the request to the medical facility ascertaining the cause of death of the victim, if such facility is a different medical facility than the facility that received the original request.

''(2) RESPONSIBILITY OF FACILITY.—Upon the receipt of a copy of a request for purposes of paragraph (1), the duties otherwise established in this part regarding medical facilities shall apply to the medical facility ascertaining the cause of death of the victim in the same manner and to the same extent as such duties apply to the medical facility originally receiving the request.

''(g) ASSISTANCE OF PUBLIC HEALTH OFFICER.—

''(1) EVALUATION OF RESPONSE OF MEDICAL FACILITY REGARDING INSUFFICIENT FACTS.—

''(A) In the case of a request under subsection (c) to which a medical facility has made the response specified in subsection (d)(4)(A) regarding the insufficiency of facts, the public health officer for the community in which the medical facility is located shall evaluate the request and the response, if the designated officer involved submits such documents to the officer with the request that the officer make such an evaluation.

''(B) As soon as is practicable after a public health officer receives a request under subparagraph (A), but not later than 48 hours after receipt of the request, the public health officer shall complete the evaluation required in such paragraph and inform the designated officer of the results of the evaluation.

''(2) FINDINGS OF EVALUATION.—

''(A) If an evaluation under paragraph (1)(A) indicates that the facts provided to the medical facility pursuant to subsection (c) were sufficient for purposes of determinations under subsection (d)(1)—

''(i) the public health officer shall, on behalf of the designated officer involved, resubmit the request to the medical facility; and

''(ii) the medical facility shall provide to the designated officer the applicable response specified in subsection (d).

''(B) If an evaluation under paragraph (1)(A) indicates that the facts provided in the request to the medical facility were insufficient for purposes of determinations specified in subsection (c)—

''(i) the public health officer shall provide advice to the designated officer regarding the collection and description of appropriate facts; and

''(ii) if sufficient facts are obtained by the designated officer—

''(I) the public health officer shall, on behalf of the designated officer involved, resubmit the request to the medical facility; and

''(II) the medical facility shall provide to the designated officer the appropriate response under subsection (c).

''SEC. 2695C. PROCEDURES FOR NOTIFICATION OF EXPOSURE.

''(a) CONTENTS OF NOTIFICATION TO OFFICER.—In making a notification required under section 2695A or section 2695B(d)(2), a medical facility shall provide—

''(1) the name of the infectious disease involved; and

''(2) the date on which the victim of the emergency involved was transported by emergency response employees to the medical facility involved.

''(b) MANNER OF NOTIFICATION.—If a notification under section 2695A or section 2695B(d)(2) is mailed or otherwise indirectly made—

''(1) the medical facility sending the notification shall, upon sending the notification, inform the designated officer to whom the notification is sent of the fact that the notification has been sent; and

''(2) such designated officer shall, not later than 10 days after being informed by the medical facility that the notification has been sent, inform such medical facility whether the designated officer has received the notification.

''SEC. 2695D. NOTIFICATION OF EMPLOYEE.

''(a) IN GENERAL.—After receiving a notification for purposes of section 2695A or 2695B(d)(2), a designated officer of emergency response employees shall, to the extent practicable, immediately notify each of such employees who—

''(1) responded to the emergency involved; and

''(2) as indicated by guidelines developed by the Secretary, may have been exposed to an infectious disease.

''(b) CERTAIN CONTENTS OF NOTIFICATION TO EMPLOYEE.—A notification under this subsection to an emergency response employee shall inform the employee of—

''(1) the fact that the employee may have been exposed to an infectious disease and the name of the disease involved;

''(2) any action by the employee that, as indicated by guidelines developed by the Secretary, is medically appropriate; and

''(3) if medically appropriate under such criteria, the date of such emergency.

''(c) RESPONSES OTHER THAN NOTIFICATION OF EXPOSURE.—After receiving a response under paragraph (3) or (4) of subsection (d) of section 2695B, or a response under subsection (g)(1) of such section, the designated officer for the employee shall, to the extent practicable, immediately inform the employee of the response.

''SEC. 2695E. SELECTION OF DESIGNATED OFFICERS.

''(a) IN GENERAL.—For the purposes of receiving notifications and responses and making requests under this part on behalf of emergency response employees, the public health officer of each State shall designate 1 official or officer of each employer of emergency response employees in the State.

''(b) PREFERENCE IN MAKING DESIGNATIONS.—In making the designations required in subsection (a), a public health officer shall give preference to individuals who are trained in the provision of health care or in the control of infectious diseases.

''SEC. 2695F. LIMITATION WITH RESPECT TO DUTIES OF MEDICAL FACILITIES.

''The duties established in this part for a medical facility—

''(1) shall apply only to medical information possessed by the facility during the period in which the facility is treating the victim for conditions arising from the emergency, or during the 60-day period beginning on the date on which the victim is transported by emergency response employees to the facility, whichever period expires first; and

''(2) shall not apply to any extent after the expiration of the 30-day period beginning on the expiration of the applicable period referred to in paragraph (1), except that such duties shall apply with respect to any request under section 2695B(c) received by a medical facility before the expiration of such 30-day period.

''SEC. 2695G. MISCELLANEOUS PROVISIONS.

''(a) LIABILITY OF MEDICAL FACILITIES, DESIGNATED OFFICERS, PUBLIC HEALTH OFFICERS, AND GOVERNING ENTITIES.—This part may not be construed to authorize any cause of action for damages or any civil penalty against any medical facility, any designated officer, any other public health officer, or any governing entity of such facility or officer for failure to comply with the duties established in this part.

''(b) TESTING.—This part may not, with respect to victims of emergencies, be construed to authorize or require a medical facility to test any such victim for any infectious disease.

''(c) CONFIDENTIALITY.—This part may not be construed to authorize or require any medical facility, any designated officer of emergency response employees, or any such employee, to disclose identifying information with respect to a victim of an emergency or with respect to an emergency response employee.

''(d) FAILURE TO PROVIDE EMERGENCY SERVICES.—This part may not be construed to authorize any emergency response employee to fail to respond, or to deny services, to any victim of an emergency.

''(e) NOTIFICATION AND REPORTING DEADLINES.—In any case in which the Secretary determines that, wholly or partially as a result of a public health emergency that has been determined pursuant to section 319(a), individuals or public or private entities are unable to comply with the requirements of this part, the Secretary may, notwithstanding any other provision of law, temporarily suspend, in whole or in part, the requirements of this part as the circumstances reasonably require. Before or promptly after such a suspension, the Secretary shall notify the Congress of such action and publish in the Federal Register a notice of the suspension.

''(f) CONTINUED APPLICATION OF STATE AND LOCAL LAW.—Nothing in this part shall be construed to limit the application of State or local laws that require the provision of data to public health authorities.

''SEC. 2695H. INJUNCTIONS REGARDING VIOLATION OF PROHIBITION.

''(a) IN GENERAL.—The Secretary may, in any court of competent jurisdiction, commence a civil action for the purpose of obtaining temporary or permanent injunctive relief with respect to any violation of this part.

''(b) FACILITATION OF INFORMATION ON VIOLATIONS.—The Secretary shall establish an administrative process for encouraging emergency response employees to provide information to the Secretary regarding violations of this part. As appropriate, the Secretary shall investigate alleged such violations and seek appropriate injunctive relief.

''SEC. 2695I. APPLICABILITY OF PART.

''This part shall not apply in a State if the chief executive officer of the State certifies to the Secretary that the law of the State is substantially consistent with this part.''.

GIRL SCOUTS USA CENTENNIAL COMMEMORATIVE COIN ACT

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of H.R. 621, which was received from the House.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 621) to require the Secretary of the Treasury to mint coins in commemoration of the centennial of the establishment of the Girl Scouts of the United States of America.

There being no objection, the Senate proceeded to consider the bill.

Mr. BROWN. Mr. President, I ask unanimous consent that the bill be read three times and passed, the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the bill be printed in the RECORD.

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

The bill (H.R. 621) was ordered to a third reading, was read the third time, and passed.

NATIONAL CHARACTER COUNTS WEEK

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 314, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 314) designating the week beginning October 18, 2009, as ''National Character Counts Week.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. DODD. Mr. President, today Senator GRASSLEY and I have submitted a resolution designating the third week of October as National Character Counts Week. In the past, my good friend Senator Domenici and I worked together on the issue of character education, and I am pleased to be joined by my colleague Senator GRASSLEY in continuing to designate a special week to this cause. I hope that with this resolution we may highlight the importance of character building activities in schools not only this week but all year long.

Since 1994, when the Partnerships in Character Education Pilot Project was first established, I have worked to commemorate National Character Counts Week. Character Counts was founded on a simple notion: our core ethical values aren't just important to us as individuals—they form the very foundation of democratic society. We know that in order to face our challenges as communities and as a Nation, we need our children to be both well-educated and trained—and that begins with instilling character in our children.

Trustworthiness, respect, responsibility, fairness, caring, and citizenship—these are the six pillars of character. Character education provides

students a context within which to learn those values and integrate them into our daily lives. Indeed, if we view education simply as the imparting of knowledge to our children, then we not only miss an opportunity, but as also jeopardize our future. Children want direction—to be taught right from wrong. Young people yearn for consistent adult involvement, and when they get it, we know they are less inclined to use illegal drugs, to vandalize or commit suicide. The American public wants character education in our schools, too. Studies show that approximately 90 percent of Americans support schools teaching character education.

Character education programs work. Currently, there are character education programs across all 50 States in rural, urban and suburban areas at every grade level. Schools across the country that have adopted strong character education programs report better student performance, fewer discipline problems, and increased student involvement within the community.

This renewed focus on character sends a wonderful message to Americans and will help reinvigorate our efforts to get communities and schools involved. With this resolution, it is my hope that even more communities will make character education a part of every child's life. I hope that my colleagues will support this important effort.

Mr. BROWN. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 314) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 314

Whereas the well-being of the United States requires that the young people of this Nation become an involved, caring citizenry of good character;

Whereas the character education of children has become more urgent, as violence by and against youth increasingly threatens the physical and psychological well-being of the people of the United States;

Whereas more than ever, children need strong and constructive guidance from their families and their communities, including schools, youth organizations, religious institutions, and civic groups;

Whereas the character of a nation is only as strong as the character of its individual citizens;

Whereas the public good is advanced when young people are taught the importance of good character and the positive effects that good character can have in personal relationships, in school, and in the workplace;

Whereas scholars and educators agree that people do not automatically develop good character and that, therefore, conscientious efforts must be made by institutions and individuals that influence youth to help young people develop the essential traits and characteristics that comprise good character;

Whereas although character development is, first and foremost, an obligation of families, the efforts of faith communities, schools, and youth, civic, and human service organizations also play an important role in fostering and promoting good character;

Whereas Congress encourages students, teachers, parents, youth, and community leaders to recognize the importance of character education in preparing young people to play a role in determining the future of the United States;

Whereas effective character education is based on core ethical values, which form the foundation of democratic society;

Whereas examples of character are trustworthiness, respect, responsibility, fairness, caring, citizenship, and honesty;

Whereas elements of character transcend cultural, religious, and socioeconomic differences;

Whereas the character and conduct of our youth reflect the character and conduct of society, and, therefore, every adult has the responsibility to teach and model ethical values and every social institution has the responsibility to promote the development of good character;

Whereas Congress encourages individuals and organizations, especially those that have an interest in the education and training of the young people of the United States, to adopt the elements of character as intrinsic to the well-being of individuals, communities, and society;

Whereas many schools in the United States recognize the need, and have taken steps, to integrate the values of their communities into their teaching activities; and

Whereas the establishment of ''National Character Counts Week'', during which individuals, families, schools, youth organizations, religious institutions, civic groups, and other organizations focus on character education, is of great benefit to the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week beginning October 18, 2009, as ''National Character Counts Week''; and

(2) calls upon the people of the United States and interested groups—

(A) to embrace the elements of character identified by local schools and communities, such as trustworthiness, respect, responsibility, fairness, caring, and citizenship; and

(B) to observe the week with appropriate ceremonies, programs, and activities.

ORDERS FOR TUESDAY, OCTOBER 20, 2009

Mr. BROWN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. tomorrow, October 20; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate then proceed to a period for the transaction of morning business for 90 minutes, with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half; that following morning business, the Senate proceed to the conference report to accompany H.R. 2892, an act to make appropriations for the Department of Homeland Security, as provided for under the previous order. Finally, I ask unanimous consent that the Senate recess from 12:30 p.m. to 2:15 p.m. to allow for the weekly caucus meetings.

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

PROGRAM

Mr. BROWN. Under the previous order, there will be up to 3 hours 15 minutes for debate with respect to the Homeland Security conference report. If all time is used, the vote would occur around 4:15 p.m.; however, we may be able to vote as early as 3:30 p.m.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. BROWN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 6:31 p.m., adjourned until Tuesday, October 20, 2009, at 10 a.m.