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Senate

The Senate met at 10 a.m. and was called to order by the Honorable KAY R. HAGAN, a Senator from the State of North Carolina.

PRAYER

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

Eternal Spirit, our shelter in the time of storm, thank You for the opportunity to serve You and our country. Remind us that You are more interested in our faithfulness than our success.

Today, empower our lawmakers to be faithful in the small things, thereby qualifying themselves for greater opportunities to serve. Make them worthy stewards of the rich resources You have given our Nation, as they remember the rich legacy of faithful labor that punctuates our history. Guide their thinking so that they will see Your plan and follow Your leading.

And Lord, on this anniversary of the attack on Pearl Harbor, we think of all the veterans of past wars, those currently in harm's way and all who have served in our Nation's military. Thank You for their sacrifices and for the faithfulness of their loved ones.

We pray in Your powerful Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable KAY R. HAGAN led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 7, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable KAY R. HAGAN, a Senator from the State of North Carolina, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

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

RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Madam President, following leader remarks, the Senate will resume consideration of the health care legislation. Following those remarks, the first 2 hours will be for debate only, with Senators permitted to speak for up to 10 minutes each. Republicans will control the first 30 minutes and the majority will control the next 30 minutes. The remaining hour will be equally divided between the two leaders or their designees. The Pryor amendment regarding enrollee satisfaction and the Gregg amendment regarding Medicare are pending. In addition, I have been informed by Senator BEN NELSON that he will offer sometime today the abortion amendment, either as the lead sponsor or as a cosponsor. We hope to complete these amendments this afternoon sometime and move on to other matters.

I should inform Members, we will not be in late tonight. There is an event at the White House that a number of Senators will be attending. So we will not be in late tonight, but the rest of the week we probably will be. As I indicated, it appears we certainly have to be in this weekend again.

HEALTH CARE REFORM

Mr. REID. Madam President, I think everyone will acknowledge the legislatively historic time in which we are now involved. We have tried to get to this point with health care legislation for almost 70 years. We are there. We can see the light at the end of the tunnel, so that people in the future will not have to file bankruptcy because they get sick. That is what happens today. For example, 750,000 people filed bankruptcy last year, as I have said here on a number of occasions, and almost 70 percent of those who filed bankruptcy did so because of medical expenses. In addition, 62 percent of those who filed because of medical expenses had insurance. That pretty well says it all.

There is not one of us who has gone home in recent months and hasn't had someone come to us in a grocery store or some other public event and say: My daughter has diabetes. She is now 23 years old. She goes off our insurance. What are we going to do? She can't get insurance.

That is going to stop. There is nothing the people of America want more than for us to do something about this. They want us to stop greedy insurance companies from denying health care to the sick and taking away your coverage at the exact time you need it the most. They want us to make it illegal for multibillion-dollar companies to say: I am sorry, your high cholesterol is going to prevent us from giving you an insurance policy or you were in an accident and badly injured your leg a few years ago and we can't give you insurance now or you are too old or you have hay fever or you have asthma. We have all heard the stories. These insurance companies say: You are on your own. Why? Because they are concerned more about their bottom line than they are about taking care of the American people. I was here a couple days ago talking about an insurance

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

company that made more than $1 billion in profits last year. Their chief executive officer made over $100 million in take-home pay. But they are still out denying coverage to everybody. These companies are not good for the American people.

What we want to do is make sure that before people get sick, they get the tests they need before these diseases start. We want women to be able to afford screenings that will catch breast cancer.

There was an interesting piece, sad though it was, on public radio this morning. African-American women get breast cancer at a much earlier age and it is a much more difficult type of breast cancer. That is why what Senator MIKULSKI did was so important. Women can now, no matter their age, have a mammogram to find out if they have breast cancer. They need these tests. We need to make sure women are able to get Pap smears when they need them and other things that are so important. Men need to be able to check for prostate cancer, which is something that has now become fixed on men's minds. It wasn't in the past.

Seniors want to be able to afford prescription drugs. They want to know their Medicare benefits will be protected.

The American people want us to make it possible for everyone to afford insurance. They know that until we do, those who do have it will keep paying extra to cover those who don't. They want us to cut the waste and fraud out of the health care system so that everyone can save money. They want us to make sure they can choose their own doctors, their own hospitals, and a health plan that is right for them. They want us to guarantee they will be able to afford health care even if they lose or change jobs.

That is why we have written a good bill, one that will make it possible for every single American to stay in a condition known as healthy. It is a bill that will make health care more affordable and health insurance companies more accountable, and it will do all this while reducing the deficit.

Yet, while the American people want us to act, our Republican colleagues in the Senate want nothing more than failure. They wanted us to do nothing. That is why Republicans have sounded a familiar cry: Slow down. Stop everything. Start over.

We have seen it again and again. They like to pretend America's health care crisis isn't a problem, that it can have some little minor tweaks here and there and everything will be fine. They choose to ignore the fact that unfair and unchecked insurance companies are forcing the very people these Senators represent to lose their homes, file for bankruptcy, and even die.

It amazes me that the Republican leader rejects the suggestion that what we are doing is truly historic. In fact, the day before yesterday he said it is ''an act of total arrogance.'' That is a direct quote. I am confident history, ironically enough, will prove the Republican leader wrong. This is indeed historic, as I began my conversation today. I am not afraid to say it is. But instead of joining us on the right side of history, all Republicans can come up with is this: Slow down. Stop everything. Let's start over.

If you think you have heard these same excuses before, you are right. When this country belatedly recognized the wrongs of slavery, there were those who dug in their heels and said: Slow down. It is too early. Let's wait. Things aren't bad enough.

When women spoke up for the right to speak up, when they wanted the vote, some insisted they simply slow down. There will be a better day to do that. Today isn't quite right.

When this body was on the verge of guaranteeing equal civil rights to everyone regardless of the color of their skin, some Senators resorted to the same filibuster threats we hear today.

And more recently, when Chairman CHRIS DODD of Connecticut, one of the people who will go down in history as the chief champion of the bill before us, said that Americans should be able to take care of their families without fear of losing their jobs, we heard the same old excuses. Through 7 years of fighting and more than one Presidential veto, it was slow down, stop everything, start over.

History is repeating itself before our eyes. There are now those who don't think it is the right time to reform health care. If not now, when? But in reality for many who feel that way, there will be never a good time to reform health care.

I know this country has never had a place for those who hope for failure. So here is whom I would rather listen to: the men and women in Nevada who write me every day. They are hardworking people, lots of different letters, really sad letters, people who play by the rules and don't understand why their health insurance system doesn't do the same. They write from the heart. Here are a couple of stories I will talk about.

A woman named Lisa lives in Gardnerville, NV, a beautiful place beneath the Sierra Nevada mountains, with her two daughters, both of whom are in elementary school. The youngest suffers seizures. Her teachers think she has a learning disability. Because of her family history, Lisa, the girl's mom, is at a high risk for cervical cancer. Although she is supposed to get an exam every 3 months, now she is not able to get one at all. When Lisa lost her job, she lost her health coverage. Now both she and her daughter miss out on the tests and preventative medicine that could keep them healthy. Her long letter to me ended with a simple plea. It wasn't slow down, stop everything, start over. It was:

> We want to go to the doctor.

Another person named Braden lives in Sparks, NV. Sparks and Reno are side by side. Braden works a 55-hour week to support his family, but it just barely pays the bills. It is not enough for him to get health insurance. He had to go to the emergency room—$12,000. It was the only place he could go. He is a brave man, though, and in his letter he doesn't dread the debt he carries, and he is going to try to pay it. He doesn't grumble about how hard he works. But he does have one fear. It is not that the Senate is doing its job. His fear is, as he wrote:

> If I was seriously sick or injured, I would lose it all.

That is the way many Americans feel.

Michelle is a 60-year-old woman who lives in Fallon, NV, about 60 miles southeast of Reno. Like so many in my State, she moved to Nevada in the last 10 years. Like so many Americans who keep our economy going, she is self-employed and has to find her own health insurance. She has two choices. One is a company that won't give her a policy because she takes three prescription medications. The insurance company only allows you to have two. So Michelle is stuck buying insurance from the other company, the only one that will sell her a plan. When Michelle moved to Nevada a few years ago, she picked the cheapest plan. Now, within 3 years, her plan costs three times as much. That doesn't include dental and vision insurance. It is very minimal, a bare-bones policy. She is waiting. But she is not waiting for us to scrap everything we have done over the past year and start over. She wrote that she is ''waiting to be old enough for Medicare to afford the surgery my doctor says I need, as I know with my current policy it will cost more than I can afford.''

These are real stories about real people: Braden, Michelle, and Lisa. They are not written with a political objective in mind. I do not know whether they are Democrats or Republicans or Independents. They have no axe to grind, as far as any partisan view. They are written by people who know that insurance companies discriminate against their policyholders, and it is not based, I repeat, on party affiliation. They are written by citizens who know this crisis is bigger than politics, and too big to ignore. They are written by Americans who want to be able to live a healthy life without going broke.

My colleagues on the other side want us to slow down, stop everything, and start over. But the course of our country goes in a different direction, only one direction. We move forward. We make progress. And when history calls on its leaders to make life better for its citizens, we answer, and we act. And we are going to act.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

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

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Pryor amendment No. 2939 (to amendment No. 2786), to require the Secretary to provide information regarding enrollee satisfaction with qualified health plans offered through an Exchange through the Internet portal.

Gregg amendment No. 2942 (to amendment No. 2786), to prevent Medicare from being raided for new entitlements and to use Medicare savings to save Medicare.

The ACTING PRESIDENT pro tempore. Under the previous order, there will be 2 hours of controlled debate, equally divided between the two leaders or their designees, with the Republicans controlling the first 30 minutes, and the majority controlling the second 30 minutes.

The Senator from Tennessee.

Mr. ALEXANDER. Madam President, on our Republican time, the Senator from Wyoming, Mr. BARRASSO, will lead a colloquy and ask for permission to do that concerning Senator GREGG's amendment, which we will be talking about this afternoon, making clear to the American people this Democratic health care bill is being paid for by treating Medicare as a piggy bank. But before we do that, I want to say, briefly, something in response to the majority leader's comments.

He, the majority leader, said the Republican leader had said the Democratic health care bill is arrogant. It is historic in its arrogance. It is arrogant to think we are wise enough—we 100 Senators are wise enough—in a 2,000-page bill to completely turn upside down and change a comprehensive health care system that affects nearly 300 million Americans and 16 or 17 percent of our economy all at once.

It is arrogant for us to imagine the American people are not wise enough to see through the proposals in this bill, which are to transfer millions more Americans into a Medicaid Program for low-income people that none of us would want our families or members a part of.

It is arrogant for us, then, to send a significant bill for much of that to State governments. We make the decision, we send them the bill, and do that in a way that in my State, at least, will cause devastating cuts in higher education or huge tax increases.

It is arrogant to say to the American people it is an $800 billion bill, which, as the Senator from New Hampshire has pointed out, when it is fully implemented it is a $2.5 trillion bill—half paid for by Medicare cuts.

It is arrogant to say we have balanced our budget when in fact—when in fact—we leave outside the budget what it costs to pay doctors to work in the government-run program we have today.

So this legislation is historic. It is historic in its arrogance, and the American people will see through it and will expect us to, instead, identify a clear goal. That is the Republican proposal, which is, to reduce costs and go step by step in a direction toward those goals—whether we are allowing small businesses to put together their plans so they can serve more people at a lower cost, whether it is creating competition by allowing people to buy insurance across State lines, whether it is reducing junk lawsuits against doctors. We have made all these proposals.

We are ready not to roll a wheelbarrow of our own in here with a comprehensive proposal. But day after day, we have said, instead of increasing costs, raising taxes, allowing premiums to go up, shifting costs to States, and dumping low-income Americans into Medicaid, let's reduce costs. We have a plan to do that.

AMENDMENT NO. 2942

I wish to recognize the Senator from Wyoming so we can have a discussion about Senator GREGG's amendment.

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

Mr. BARRASSO. Mr. President, I ask unanimous consent to engage in a colloquy with my colleagues to discuss the issues at hand.

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

Mr. BARRASSO. I thank the Presiding Officer.

Mr. President, I have been looking at the bill, which, to me, is going to hurt the health care system of our country. I am a physician. I have taken care of families in Wyoming for 25 years, and I think if we want to get costs under control, if we want to help families all across America who are struggling with their health care needs, we need to focus on an amendment that is before us today, brought forward by the Senator from New Hampshire.

I ask my friend and colleague from New Hampshire, is it not true that the numbers we are looking at are underreported? It is going to be much more expensive and the cuts are going to come from our seniors, those who are vulnerable, those who depend on Medicare for their health care, and we need to make sure and promise the American people we will be protecting those folks who depend on Medicare for their health care?

Mr. GREGG. Mr. President, the Senator from Wyoming, first as a doctor and second as a Senator, raises a very important point; that is, this is the largest expansion in government in the history of the government.

Let's begin right there. This is a $2.5 trillion expansion in the size of the government when fully implemented. It is a massive growth in the size of government. Most of that growth comes from the expansion of government in two areas: the expansion and creation of a brand new entitlement and the expansion of Medicaid, as was alluded to by the Senator from Tennessee.

How is that paid for? How is this huge explosion in the size of government paid for? Well, a large part of that is paid for by reducing the amount of money in Medicare that is paid in Medicare, paid to Medicare providers, and available to Medicare recipients—$460 billion in the first 10 years, $1 trillion in the first 10 years when the program is fully implemented—that would start in about 5 years—and then $3 trillion, by our estimates, which are linear—I suspect it will be more—over the first 20 years of this bill, a $3 trillion reduction in Medicare benefits.

We heard arguments from the other side of the aisle: Oh, that is not going to affect benefits. Well, that is not believable. We know that. You cannot reduce Medicare provider payments and you cannot cut Medicare Advantage—with the total cuts of both, combined, by $460 billion in the first 5 years, $1 trillion in the first 10 years of full implementation, and $3 trillion over 20 years—and not affect benefits.

This is money that is going to have the most significant impact we have ever had occur on our seniors in their Medicare system. This is a fundamental change in the way Medicare services are paid for and the insurance that is available to seniors under Medicare, specifically, Medicare Advantage. We know for a fact that of the 11 million people on Medicare Advantage, approximately a fourth of them will lose it—simply lose their Medicare Advantage.

We also know hospital groups, provider groups, and doctors are all going to see significant reductions in their reimbursement rates, which means, of course, they are going to change the way in which they treat seniors. Seniors are going to find it harder to find a doctor. They are going to find it harder to get a procedure they need because the reimbursement rate for those procedures is going to have been cut so significantly under this bill.

Home health care will be dramatically impacted. The Senator from Wyoming had a very interesting letter from his home health care groups in Wyoming which related to what percentage of home health care agencies would actually close. It was a very high percentage under this proposal.

There is no question but that Medicare is in dire straights. It is headed toward insolvency. It goes into a negative cashflow in 2 years, and it has $35 trillion of obligations, which we have no idea how we are going to pay for. So Medicare reform is important. I have supported it. I proposed it. In fact, I proposed it a number of times and have always been voted against by colleagues on the other side of the aisle.

But any reform to Medicare of this size—$464 billion in the first 10 years,

$1 trillion in the first 10 years of implementation, $3 trillion over 20 years—anything that is going to cut Medicare by those numbers, those savings, if they are going to occur, those reductions, should go to benefit making Medicare more solvent.

But what happens under this bill? That is not what they are used for. Those dollars which come right out of the pockets of seniors and the people who provide seniors care—and the ability of seniors to purchase insurance under Medicare Advantage—those dollars go from the senior over to creating these new major programs, these new entitlements.

In fact, I was looking at the bill. It appears to me some of those dollars go to get votes around here. Isn't that incredible? They are going to take money away from seniors and use it for the purposes of getting votes to pass this bill by sending money back to States of Members who are maybe a little wavery on whether they want to vote for this bill. That is where some of the money goes.

But most of the money goes to creating these new entitlements for people who may be deserving—probably are deserving—but who are not seniors and who probably have not paid into the insurance fund that seniors have paid into for all their life and, thus, it is totally inappropriate to do that.

I have an amendment. It is very simple. It is an amendment that has real teeth, and it is actually an amendment that follows up on a number of statements from the other side of the aisle and some sense of the Senate which were voted 100 to nothing around here, which says, simply: No Medicare money can be used to fund other parts of this bill. To the extent Medicare savings occur under this bill as a result of cuts to home health care, cuts to Medicare Advantage, cuts to provider groups, those dollars will not be taken and used to fund new entitlements for people who are not on Medicare, not seniors. They will not be taken to fund the purchase of votes around here to pass this bill.

This is a real amendment. A lot of stuff happening around here is sense of the Senate, where people stand up and say: Oh, I am for that. Exactly, what I said—let's do a sense of the Senate to that effect.

But sense of the Senate has no impact at all. It is political cover. This is not political cover. This amendment, as structured, will actually accomplish the goal of not allowing Medicare dollars—cuts in Medicare that are $464 billion over the first 10 years, $1 trillion over the fully implemented period, and $3 trillion over the 20-year period—it will not allow any of those dollars to be used to fund new programs in this bill which do not benefit seniors.

That is all it says. It seems to me, if you are going to stand up for responsible action in the area of Medicare, if you are going to live by the sense of the Senate that have been voted for here, if you are going to stand behind your word, as the sense of the Senate have called for—that Medicare money be used for Medicare, and that Medicare money not be used to fund things that are extraneous to Medicare; Medicare cuts savings—then you have to vote for this amendment.

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

Mr. GREGG. I would be happy to yield.

Mr. THUNE. It strikes me that the Senator's amendment is very straightforward, very simple, and very clear; that is, any savings that come out of the Medicare Program cannot be used to fund a new entitlement program.

Mr. GREGG. That is not related to seniors.

Mr. THUNE. Correct. And it seems to me, at least, that the amendment gets at what some on the other side have argued, with their amendments, they are trying to accomplish.

Could the Senator from New Hampshire describe how the effect, the legal effect, of his amendment differs from, say, for example, the votes we have had, where it was a 100-to-0 vote the other day on a Bennet amendment, what the impact the amendment of the Senator from New Hampshire would be relative to some of the previous votes we have had, which it appears to me, at least, were completely meaningless, sort of cover votes, to try and give people on the other side the opportunity to say: We voted to protect Medicare, when, in fact, they did not?

How is the amendment of the Senator from New Hampshire distinguished from those that have been voted on previously?

Mr. GREGG. My amendment has force of law behind it. Those amendments have no force of law behind them. They have no effect at all. As the Senator said: a political statement, an editorial comment, a piece of paper written.

This amendment, if passed, will have the force of law behind it. It will very simply be structured in a way that the money cannot be taken out of Medicare if it is going to be used for the purposes of funding the new programs in this bill, whether they are the entitlement programs for people who are not seniors—this expansion of entitlements—or whether they are for the purposes of getting votes to pass the bill.

Mr. THUNE. So if a Senator on either side of the aisle, a Republican on this side or a Democrat, was serious about protecting Medicare, ensuring that Medicare's solvency is protected and that these funds are not going to be reallocated to create some new entitlement program or spend money on some new, clearly, $2½ trillion expansion of government, which we know is going to require enormous amounts of revenue which seems to me has to come from somewhere—what the Senator's amendment would do is simply force the other side to put up or shut up with regard to this argument they have, which is that they are, in fact, supporting Medicare; the Senator's amendment would essentially say, very clearly, in a very straightforward way, that funds that come in out of savings from Medicare have to be retained in the Medicare account.

Mr. GREGG. That is correct. This is the first and only vote Members on this floor are going to have, to make it clear that Medicare dollars will not be used for something other than Medicare.

Mr. CHAMBLISS. Would the Senator yield for an additional question? The language in the Bennet amendment that passed 100 to nothing the other day said, basically, that Medicare savings should benefit the Medicare Program and Medicare beneficiaries. That sounds pretty straightforward, pretty simple. But let me ask the Senator—

Mr. GREGG. Well, if I might interject, anybody who voted for that amendment would want to vote for mine.

Mr. CHAMBLISS. That is exactly the question I am getting to. Is there anything in the Bennet amendment that removes the expenditure of almost $500 billion from Medicare in the base Reid bill that would require the restoration of those cuts to benefit Medicare versus using it as a fund to pay for the underlying Reid bill?

Mr. GREGG. Well, the Senator has made an excellent point. Essentially, the Bennet amendment has no teeth. It has no substance. It has no substantive effect. It is just a statement of purpose. If the statement of purpose is as recited by the Senator from Georgia, then you would need to vote for this amendment, my amendment, if you voted for the Bennet amendment, because my amendment has the teeth that backs up the language of the Bennet amendment.

Mr. CHAMBLISS. If I understand what the Senator is saying in his amendment, he is requiring the Office of Management and Budget as well as CMS to certify to Congress, basically, that the savings that are referred to in the Bennet amendment as well as in the Senator's amendment are, in fact, being used to fund Medicare benefits versus being used to fund other benefits outside Medicare until such time as Medicare is fully funded.

Mr. GREGG. That is, essentially, what it says. It says that CMS and OMB must certify that no funds are being used to fund the additional activity in this bill that does not relate to Medicare with Medicare funds. It does not say that Medicare savings—it agrees to the Medicare savings, but those Medicare savings would basically be used for the purposes of reducing the outyear fiscal imbalance of Medicare. So it doesn't contest the Medicare savings as proposed in this bill, although those amendments have—we have already voted on a number of those. We voted on home health care, and we voted on Medicare Advantage, but to the extent those savings go in, those

cuts in Medicare benefits go in, the revenues from those cuts cannot be used and spent to expand the size of government in someplace else which has nothing to do with senior citizens.

Mr. BARRASSO. If I could follow up with a question for my colleague from New Hampshire, because as I read the Sunday New York Times, it said the Bennet amendment was completely meaningless—the Bennet amendment was meaningless. It also goes on to say, Senator MCCAIN is trying to keep that $500 billion in Medicare, but the Democrats are trying to take that money out of Medicare and, as the article says, the editorial says: to finance coverage for uninsured Americans but not people on Medicare.

So it does seem the New York Times, at least in this segment, got it right: that the Bennet amendment that our colleague from Georgia referred to is meaningless, that the cuts are going to come out of people who depend upon Medicare for their health care to pay for a whole new government program and not to focus on Medicare.

Well, don't we owe it to these seniors who have paid into the program and who have been promised the program to save that program first?

Mr. GREGG. Well, the Senator from Wyoming is absolutely right. I think the New York Times got it right. It is a convergence of two unique forces of nature that the Republican minority in the Senate and the New York Times should be on the exact same page on this issue and both be right.

Mr. ALEXANDER. I wonder if the Senator from New Hampshire would characterize this discussion this way: As I am hearing it, in order to protect Medicare, a Senator wouldn't want to say: I voted for the Bennet amendment and then I voted against the Gregg amendment, when it counted.

Mr. GREGG. It would be virtually impossible to make that argument with a straight face.

Mr. BARRASSO. I have a question for my Senate colleague from South Dakota who is here. We heard the majority leader, Senator REID, come to the floor a few minutes ago and talk about how this bill is going to get premiums under control, keep the cost—for people who have insurance, keep their premiums under control. I saw a chart from the Senator from South Dakota yesterday that said for 90 percent of Americans, those who have insurance now, if we did nothing and did not pass this bill, the premiums would be lower than if we do pass this bill; that passing this bill actually will raise premiums, in spite of the fact the President of the United States promised, while campaigning, that he would lower the cost of premiums for American families by $2,500.

I would ask my colleague from South Dakota, isn't it true that if this bill passes, Americans wanting—feeling they have been promised that premiums would be reduced, are they not doomed to disappointment?

Mr. THUNE. The Senator from Wyoming is correct. This is where the real rub in this bill comes into play because what we were told and the promises that were made—of course, many promises were made throughout the course of the campaign, many of which will never be realized with this legislation. There was also a promise made that taxes wouldn't go up for people making less than $250,000 a year—not payroll taxes, not income taxes, not any kind of taxes. In fact, we now know that 38 percent of the people who make under $200,000 a year are going to see their taxes go up under this legislation. So promises made during a campaign season tend not to necessarily be adhered to when it comes time to legislate and actually follow through, and I think that is clearly the case here.

With regard to the question of the Senator from Wyoming, the whole purpose of health care reform, at least as I understand it—and I think, for the most part, as the people of South Dakota whom I represent understand it—is to lower cost. Because everybody complains—the thing you hear the most when you go home—and the Senator from Georgia is here. If you go to Georgia, Wyoming, South Dakota, I think the sentiment you hear most frequently from people in our States is: Do something about the cost of health care. We have these year-over-year, double-digit increases or increases that are twice the rate of inflation, and we are dealing with this. Small businesses are dealing with it. More and more people—families are struggling with the high cost of health care. Nobody argues that. We all, basically, accept the premise that health care costs have been going up and health care reform ought to be focused directly on trying to get those costs under control.

The irony in all this is, after cutting $½ trillion from Medicare in the first 10 years, and if you go into the fully implemented time period it is about $1 trillion, and $½ trillion in tax increases, what happens with premiums? Well, according to the Congressional Budget Office, 90 percent of Americans would be the same or worse off. In other words, 90 percent of Americans would see no improvement in their health insurance premiums. In fact, if you buy in a small group market, if you buy in a large group market, your premiums go up by about 6 percent a year, year over year. In fact, a family of four—let's put it in a perspective that an American family can understand. If you are a family of four—this is according to the Congressional Budget Office—that is paying $13,900 for insurance this year and you are getting your insurance in a large group market because you work for a large employer, in 2016, your insurance cost is going to be over $20,000 a year. In other words, your insurance is going to go up about—a little under $14,000 to over $20,000 a year in that time period.

So what American in their right mind is going to say that is reform? I think most Americans are going to say: What are you doing? You are spending $2.5 trillion, you are raising my taxes, and cutting my parents' or my grandparents' Medicare benefits, for what? So my premiums can stay the same or go up? If you buy your insurance in the individual marketplace, your insurance premiums, according, again, to the Congressional Budget Office, are going to go up anywhere from 10 to 13 percent a year. So you get Medicare cuts, you get tax increases, and for 90 percent of Americans, you stay the same or are worse off. In other words, your insurance premiums are now going to be impacted, you have achieved the status quo or, worse yet, your insurance premiums are going to go up 10 to 13 percent if you are buying in the individual market. That is according to the Congressional Budget Office.

So I would say to my friend from Wyoming, the point he made is exactly right. In doing all this, the exercise ought to be about reducing costs. Clearly, that is not the case with this legislation.

Mr. CHAMBLISS. Let me address a question to our friend from Wyoming who is a medical doctor, in addition to being an outstanding Senator.

What we are being asked to believe from the folks on the other side and what the American people are struggling with and having a hard time believing is, they are saying that even though they are cutting Medicare by a total of $450 billion-plus over a 10-year period, actually the solvency of Medicare is going to be extended. They expect the American people to believe that somehow.

The fact is, we know from the information we received this spring from the bipartisan Medicare Commission, unless something is done, Medicare is going to become insolvent in the year 2017, pure and simple. What we are doing is not taking the savings they are proposing—and we don't agree with them, but irrespective of that—irrespective of the savings they are saying are going to be achieved, instead of applying that back, we are going to use that to grow the size of government, tie some reimbursement payments to physicians to the Medicare Program, and now we are looking at about a 23-percent reduction in payments to physicians as reimbursement under Medicare if we don't take some action next year. When you put all this together, the American people are saying: You have to be kidding me. How in the world are you going to extend the life of Medicare by cutting it by almost $500 billion?

Mr. BARRASSO. As my colleague from Georgia knows, there is no way you can save Medicare when you cut that kind of money out of it. How, when they cut physicians' payments by 23 percent, are we going to have physicians going to any of our small communities in South Dakota, in Georgia, in Wyoming, where we have many people

who depend on Medicare for their health care? I worry about access to care.

Our colleague, Senator ISAKSON, yesterday talked about home health care and how, for pennies on the dollar, you can help people. It provides a lifeline for people who are homebound. It keeps them out of the hospital, out of the nursing homes. Instead, this Senate, the Democratically led Senate, yesterday voted to cut $42 billion out of home health care, which people in our small communities and in the rural areas of our State depend upon. So there is no way this program can stay solvent.

It is hard for me to fathom and, clearly, hard for the people of Wyoming to fathom, how with all this budget trickery it is going to work for people who need to go to see a doctor or to have a home health care provider in many of our rural communities.

We all have townhall meetings, and when I go to townhall meetings, people say: Don't cut my Medicare, don't raise my taxes, and don't make things worse for me than they are now.

Mr. THUNE. If the Senator will yield, the Senator, of course, is one of only two physicians in the Senate and has great experience and great depth on this issue and knows what it is like to serve and provide health care services to people in rural areas, such Wyoming and South Dakota and some areas of Georgia.

I think it is interesting too—and the Senator from Georgia was here, as was I; I don't think the Senator from Wyoming was here at the time. But in 2005, we had a debate about Medicare, and the Senator from New Hampshire proposed cutting $10 billion in Medicare, taking $10 billion over a 5-year period or about $2 billion a year, and paid for it by income testing the Part D benefit that people got. In other words, the premiums that are paid, those who are in the higher income categories would have to pay a higher premium for their Part B drug benefit than would those in lower income categories. You would have thought that the apocalyptic pronouncements and predictions around here about what that was going to do for Medicare: $2 billion a year or $10 billion over 5 and you heard the other side describe it as immoral, it was cruel, it was a disaster of monumental proportions. That was some of the terminology that was used around here at the time. That was for $10 billion over 5 years, and that basically was to say to people who have higher incomes, the Warren Buffetts of the world ought to pay a little bit more for their prescription drug benefit under Medicare than those in lower income categories, and people on the other side went nuts about that.

Now here we are talking about cutting $465 billion over a 10-year period, $1 trillion over 10 years, when it is fully implemented, and it seems to me, I would say to my colleagues, the other side is going to have a lot of explaining to do to the American people about why $10 billion in reductions was immoral, cruel, and a disaster of monumental proportions, but cutting $½ trillion out of home health care and nursing homes and hospitals and everything else to pay for an entirely new entitlement program, a $2.5 trillion expansion, somehow makes sense.

Mr. BARRASSO. Mr. President, I appreciate the comments from my colleagues. I think we are hearing around the country that we do need health care reform. We need to get costs under control. We need to have patient-centered reform, not government-centered reform, not insurance-centered reform. We need to not cut Medicare. We need to not raise taxes. We need to not make things worse for the American people.

From what I have seen of this bill—and I worked my way all the way through it—it makes things worse for the American people, not better. This is not the right prescription for health care in America.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, for the benefit of all Senators, I will take a moment to lay out today's program. It has been 2½ weeks since the majority leader moved to proceed to the health care reform legislation. This is the eighth day of debate. The Senate has considered 16 amendments and motions and conducted 12 rollcall votes.

Today, we will debate an amendment by Senator PRYOR and, at the same time, an amendment by Senator GREGG to do with spending taking effect. The first 2 hours will be equally divided. The Republicans will control the first 30 minutes and the majority will control the next 30 minutes. There may or may not be a side-by-side amendment to the Gregg amendment. The Senate will conduct votes on or in relation to the Pryor and Gregg amendments this afternoon. We expect at least those votes to begin sometime between 3:15 and 4 p.m. this afternoon.

I will take a few moments to discuss the amendment Senator GREGG offered yesterday. The Gregg amendment has been billed as protecting Medicare. That seems to be the new fashion on the other side of the aisle—to say that the bill cuts Medicare. Frankly, that is a misleading statement at best, and it is inaccurate, basically. In reality, the Gregg amendment is a killer amendment. It is designed to prevent health care reform from taking effect. That is the purpose of the Gregg amendment. It is a killer amendment.

The amendment has more details to it, but you can get the flavor of it from a few excerpts. Let me quote from the amendment.

The first subsection of the amendment is entitled ''Ban on New Spending Taking Effect.'' You really don't have to go much further to get an idea of what the amendment is about. Just focus on that statement in the amendment—a ban on new spending taking effect.

Let me quote further from the second subsection:

. . . the Secretary of the Treasury and the Secretary of Health and Human Services are prohibited from implementing the provisions of, and amendments made by, sections 1401, 1402, 2001 and 2101. . . .

What are those sections? The Gregg amendment will stop this spending from taking effect.

Section 1401 is refundable tax credits providing premium assistance for coverage. Those are the tax credits, the tax reductions that help people buy health insurance. The Gregg amendment says we cannot help people buy health insurance, that they can't have those tax credits.

The second section is 1402. What is that? It is to reduce cost sharing for individuals. That is the part that would make copays and other out-of-pocket expenses affordable. The Gregg amendment says: No, we can't have reduced cost sharing for individuals. We have to keep those copays in effect and out-of-pocket expenses high. It would help people with copays and other out-of-pocket expenses.

The third section the Gregg amendment would stop is section 2001. It is a section that provides Medicaid coverage for the lowest income population. That is the one that provides expanded Medicaid coverage up to 133 percent of poverty. The Gregg amendment says: No, you can't help poor people with health care. The Secretary is prohibited from making those payments to Medicaid if that amendment is adopted.

The fourth section the Gregg amendment would stop is section 2101. Section 2101 is a section that provides additional funding for the Children's Health Insurance Program. Can you believe that? A Senator gets up on the floor of the Senate and wants to stop funding to the Children's Health Insurance Program? That is what that section provides.

So if you don't like tax reductions to help people buy health insurance, if you don't like making health insurance affordable, if you don't like health care for the lowest income Americans, and if you don't like health care for kids, then the Gregg amendment is for you.

The folks on the other side of the aisle have spent a lot of time this year talking about Medicare. That is about all I hear from them. They make it sound as if they want to help Medicare. In effect, they are hurting it. A lot of folks say they want to help Medicare, and I see the big crocodile tears they shed. I will take a few moments to set the record straight about how the trust fund works. That might help them understand, frankly, why the bill before us—the Reid bill—helps Medicare, contrary to protestations of those on the other side.

The Medicare trust fund provides hospital insurance for seniors and Americans who are disabled. Working Americans pay into that trust fund when they pay their payroll taxes.

When a senior has to go to the hospital or a nursing home—there are lots of areas where seniors get help—the spending to help pay for that hospitalization comes out of the trust fund. The actual sum comes out of Medicaid, but some payments come out of the Medicare trust fund, such as for home health care, et cetera.

When payroll tax revenues are greater than the payments for hospitalizations, the assets in the Medicare trust fund grow. That is good. On the other hand, when spending for hospital care is greater than payroll tax revenues and interest payments on the trust fund assets, then assets in the Medicare trust fund diminish. That is not good.

The Actuary for Medicare—the person charged with determining the health of the Medicare trust fund over at HHS—tells us that if we don't do anything—if this legislation is not passed—then by about 2017 the Medicare trust fund assets will be exhausted. That is clear. That is definite. That is a fact, and I emphasize the word ''fact.'' I am just being honest, Mr. President. I have to be objective and honest about this stuff. When I hear Senators talk about Medicare, they are not looking at facts. It is one thing to say something and engage in all this rhetoric, but if it is not backed by facts, it is a bit irresponsible.

The fact is, the life of the Medicare trust fund will be extended for 5 years under this legislation. I talked to a Senator on that side privately. He said that the Medicare trust fund will not be extended—the solvency—for 5 years. I asked him privately: How can that be true? Did you read the Actuary's report? By the way, it was not this Senator right here; it was another Senator, and that Senator said: I don't believe it. It is a fact. The Actuary says that will be the result of the legislation before us; namely, that the solvency of the trust fund will last 5 more years. That is a fact. That is what the Actuary's report said.

So we can either raise more payroll taxes to continue the solvency of the trust fund so that seniors get their benefits or we can reduce spending out of the trust fund. We can either increase the money or decrease the money coming out.

I will say it again. The Medicare Actuary tells us that health care reform will extend the life of the Medicare trust fund by 5 years or, to put it another way, if we do not enact health care reform, we will hurt Medicare's long-term solvency.

Let me cite some examples on how that works.

Health care reform would discourage hospital readmissions, for example. That is waste. See, here is what the other side doesn't quite understand. You don't hear them talking about it. The goal here is to extend the life of the trust fund, basically by cutting out waste—not hurting seniors but cutting out waste and cutting back on overpayments in some areas where some providers are overpaid, and where seniors are helped, not hurt.

Again, here is an example: hospital readmissions. If you can discourage hospital readmissions, that is fewer dollars wasted out of the trust fund, and it is better health care for seniors. The incentive is for hospitals to have more readmissions because that is how they make money. Some hospitals, frankly, don't go out of their way to prevent readmissions because they can make more money that way, although it is not good care for seniors.

When a senior is discharged from a hospital, you want to make sure there is a flow, a seamless effort of keeping health care for that patient, whether it is extended care or home health care in a nursing home or whatnot, and there is a physician involved and nurses involved and so forth, making sure the patient is taking his or her medication, and it is just to make sure patients are getting better all the time.

We all know—I know because I have experienced it, and I have watched it firsthand, and I have heard many people talk about this—that too often, when a patient is discharged, the care for that patient is not as great, as the hospital is in longer involved, and sometimes the regular doctor is not involved because that doctor is not very much involved with the patient at the hospital. My own view is that it needs improvement. It is not working too well.

Again, we are saving dollars in the Medicare trust fund by preventing excessive readmissions. That is wasteful and doesn't help the patient. So that is a way we are saving and extending the solvency of the trust fund. That is one way. There are others. I will cite a second.

Health care reform discourages hospital-acquired infections. I think in America, unfortunately—and I don't know the facts, but I have read this somewhere, but I haven't confirmed it—the rate of infections in American hospitals is greater than it is for other industrialized countries. That is clearly a problem. People die from infections in hospitals, and it seems to me that the more we can encourage fewer infections—one way is through health care reform. Maybe we can lower payments to hospitals that have too many infections. I know it is hard to do. It is a judgment call. You have to do the best you can. That, too, will help the solvency of the trust fund and help care for patients. That is another way we are extending solvency of the trust fund.

I see my good friend from Wyoming on the floor, Senator BARRASSO, who talks about home health care. I am sure he wants to eliminate fraud in home health care. I am sure he does. We all want to. So we cut back on areas where there is fraud. Where is there fraud? In outliers. Too many hospitals bill too much for outlier payments, additional payments, because they say they have a special patient who is an outlier. One county in Florida billed for 60 percent of the outlier payments in America even though they had 1 percent of seniors in America. There are other examples like that. The GAO came to us and said we have to do something about this. There is fraud in the home health care program. I am a big fan of home health care—a big, big fan. They do very good work. But we want to take out the fraud—excessive payments that are fraudulent. Isn't that a good thing? Doesn't that extend the solvency of the trust fund? Isn't that helping patients instead of hurting them?

There are examples. The home health folks came to us and said: Make some of these changes because it is more efficient and we can give better care. As a result, fewer dollars are going to home health care. We also had a provision for rural health care. We add an extra bonus for rural health care.

My point is simply that when Senators stand up on the floor and say we are cutting Medicare—sometimes they use the words ''cutting benefits'' or ''hurting beneficiaries''—that is patently false. It is not true. It is true that in some cases we are taking some of the fraud out. It is also true that in some cases we are taking excessive payments—not by our judgment but by the judgment of MedPAC and other organizations and experts who study this. One Senator from Florida stood up and told me he agreed that payments to Medicare Advantage are excessive. Doesn't it make sense to take out the excess, the waste, and the fraud in order to extend the solvency of the trust fund? That is what this bill does.

It doesn't hurt seniors by ''cutting'' Medicare, leaving the implication that we are cutting Medicare benefits. It is an old saying in life: If you say something loud enough, maybe people will start to believe it. That is what the other side is engaging in.

If you look at the actual facts, the actuary says it does extend the life and solvency of the trust fund. The actual fact is we are cutting out waste. The actual fact is the industry has come to us and said: Help us with this, help us with that so we can be more efficient, much of what is going on here.

I have countless examples. Let me give a third one. This legislation would encourage hospitals and doctors to work together by bundling payments. If doctors and hospitals work together, guess what happens. They are less likely to order duplicate tests. They are working together. Payments based on fee for service, payments based today on volume, on quantity are, in some cases, wasteful. It is wasteful.

All of us who go to a hospital, a doctor's office, we kind of wonder: My gosh, some things seem wasteful here. We have to get new tests, new this; the doctor doesn't know what happened when I was here previously; we have to start all over again; new x rays, new imaging, so forth. They are waste. We

are trying to cut out a lot of this waste, and bundling payments is definitely going to help.

We have other techniques—accountable care organizations, medical home concepts. These could take 1 year, 2, 3, or 4 to kick in. But if they do work, it is the model of integrated care systems we all talked about which cut out waste and improve quality at the same time, and that is going to help Medicare. These integrated systems are going to also help extend the solvency of the trust fund and improve quality of care—not reduce it but improve it.

The main point I am making is these reforms will extend the life of the trust fund. And guess what. They improve the quality of care, not decrease the quality of care but improve it.

We also add some additional benefits for seniors that they will not receive if this legislation does not go into effect.

I note we only have a half hour on our side. I probably used more time than I should. The chairman of the HELP Committee is on the floor. Mr. President, how much time remains on the majority side?

The PRESIDING OFFICER. Thirteen minutes remains.

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

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, I thank my colleague from Montana, the chairman of the Finance Committee, for his great leadership on this issue, on this bill, and Senator DODD, who took the leadership of our HELP Committee, in putting our bill together. The two of them have done an admirable job of getting our bill this far along and, hopefully, we are going to see the light at the end of the tunnel pretty soon. One of the best Christmas presents we can give the American people is to bring this bill to a close, have our votes up or down and let's get this bill passed so the American people can look ahead to a brighter future in terms of their health care and its quality, affordability, and accessibility.

AMENDMENT NO. 2939

I wish to take a little bit of time this morning to speak in strong support of Senator PRYOR's amendment, which is before us, which would provide information on the consumer satisfaction of health plans offered through the exchanges. The Pryor amendment develops an enrollee satisfaction survey for these plans and requires exchanges to include information from this survey on an Internet Web site. This, too, will allow consumers, both individuals and small businesses, to easily compare survey results and make well-informed choices.

Currently, OPM manages an enrollee satisfaction survey for the Federal Employees Health Benefits Plan, the one we are all in and the one our staffs are in, the one that postal workers are in and civil servants all over this country are in. Right now OPM, in managing that plan, has an enrollee satisfaction survey. The Pryor amendment would provide a tool to all Americans that we as Members of Congress have when we select a plan.

The survey results could be used by GAO, the Government Accountability Office, and the committee I chair, the Senate HELP Committee, to monitor the quality of exchange plans and fulfill our oversight responsibilities over the exchanges.

As a little aside, I keep reminding people we will pass this bill, we will get this health reform bill passed. It will be signed into law. But that does not mean, like the Ten Commandments, it is written in stone, never to be changed. Laws are laws and laws change. They get amended, and we change and adapt as times and conditions demand. As we move ahead and as we look at how the exchanges work, what is happening out there, I have no doubt in my mind there will be some bumps in the road and we will have to come back and revisit it and make some changes. By having this Pryor amendment and what we have in the bill to provide for this kind of survey to see how satisfied people are with the plans, it gives us that kind of oversight ability, that oversight responsibility to look ahead and plan on changes that we will probably be making in the future.

But most important, the Pryor amendment will give consumers an important voice. It will keep the insurance companies honest because they will know to maintain and grow their enrollment they must satisfy their customers.

This amendment truly complements and reinforces the purpose and function of the exchanges. The Patient Protection and Affordable Care Act, our reform bill, creates exchanges as a place for one-stop shopping where consumers, the self-employed, and small businesses can easily compare plans. This amendment will increase competition and lower premiums as the exchanges will increase competition and lower premiums.

This past week, the Congressional Budget Office validated this approach, and the CBO said this about the exchanges:

The exchanges would enhance competition among insurers in the nongroup market—

That is small businesses, individuals, self-employed—

by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees.

What we have been hearing from the other side of the aisle all along is premiums are going to go up, everything is going to skyrocket. CBO debunked this last week. CBO also said it will benefit small business:

Those small employers that purchase coverage through the exchanges would see similar reductions in premiums because of the increased competition among plans.

The Senate bill before us ensures consumers and small businesses have the information they need to make informed choices.

One, our bill requires exchange plans to provide information on quality measures for health plan performance. This was a provision offered in our committee by Senator JACK REED, and I commend him for it.

Second, our bill develops a rating system that will rate exchange plans based on quality and price—ratings, again, that will be available on an Internet Web site.

Third, our bill requires exchanges to operate a toll-free hotline to respond to requests for consumer assistance.

Fourth, our bill develops an online calculator so that consumers can figure out how much they will have to pay, factoring in their tax credits and cost-sharing reductions.

And fifth, and perhaps most important, I want to acknowledge a contribution made by Senator DODD in this area. He authored a key provision in our bill to require all plans—all plans—not just exchange plans, all plans—to provide a uniform, easily understandable summary of coverage to enrollees and applicants. In other words, no longer will Americans have to read and try to comprehend the fine print.

All of these provisions are currently in our bill to enhance consumer choice, which is what this bill is about—enhancing and expanding affordable choices.

Some of them have been overlooked in a lot of the verbiage going on about cutting Medicare and all that stuff, but these provisions will do a great deal to change the way Americans shop for and buy health insurance.

This amendment by Senator PRYOR will add one more important tool to help our consumers. It is a consumer amendment to make sure consumers get the information they need and the input, a satisfaction survey so consumers can have an input. That way we know here if we need to make changes down the road.

I commend Senator PRYOR for offering the amendment. I urge my colleagues to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent to speak as in morning business for up to 7 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. BARRASSO. No objection.

The PRESIDING OFFICER. No objection is heard. The Senator may speak for up to 7 minutes.

Ms. KLOBUCHAR. Mr. President, I rise today in support of the amendment offered by Senator PRYOR that calls for an enrollee satisfaction survey for health care plans offered through the exchange. As you know, the exchange

will be a series of different policies from which people can choose. What I love about this idea is that for my small businesses and self-employed who are paying 20 percent more than people who work for big businesses right now because they simply cannot leverage their numbers, it is hard for them to get good rates because they are out there on their own, this exchange, where they can choose a number of different policies like Members of Congress can choose from, whether it is Blue Cross or a number of the other choices, they can pick a policy on the exchange.

I serve with Senator PRYOR on the Consumer Protection Subcommittee and know that he offers this amendment with the full intent of improving resources for individuals who buy insurance. A satisfaction survey will be a tool to help consumers navigate through the complicated process of purchasing health insurance. The survey results will allow individuals and small businesses to make well-informed health care decisions by comparing current enrollee satisfaction levels among the plans offered through the exchange.

This survey also provides, as Senator HARKIN has pointed out, an oversight tool for Congress so we can monitor the progress of the exchange and present information to patients in an open, transparent manner.

As I have said many times, I come from Minnesota, often known as a ''medical Mecca.'' We are home to the Mayo Clinic. We are home to the University of Minnesota. Countless innovative businesses have contributed groundbreaking medical research that is bettering the lives of patients.

The key to this Minnesota model, where we have some of the highest quality care in the country and some of the lowest costs, is by putting the patient in the driver's seat. I have been at the Mayo Clinic. I have seen what happens there. It is integrated care with one primary doctor with a group of doctors that work with him, like a quarterback on a football team. They also focus on the patients with satisfaction surveys, keeping the team accountable for what they are doing.

I always say to my colleagues, it is counterintuitive. If you go to a hotel and pay more money, you often get the best room with a view. That is not true with health care in America. You can pay more money and get some of the worst quality care in this country because there is no accountability. That is why these patient surveys, in allowing consumers in this country to look at these different plans and figure out which one is better for them, is the way to go.

In my State, 92 percent are covered by some form of health insurance, and we have done that by learning the importance of transparency and providing quality information to consumers.

In 2004, a Minneapolis-based nonprofit called Minnesota Community Measurement developed a consumer resource called Developed HealthScores. HealthScores is based on information submitted by more than 300 clinics statewide and is available to consumers on an easily accessible Web site.

HealthScores is also used by medical groups and clinics to improve patient care and by employers and patients to provide access to critical information about the quality of health care services.

Researchers at the University of Oregon have studied public reporting efforts and found that public reporting motivates health care providers and insurers to work harder on improving care, largely because of a concern about their reputation.

This is how the private market should work. You cannot just have insurance policies that have a name and not understand what they mean for the consumer. By having these surveys, we are going to be able to understand so a consumer can navigate through and figure out which policy is good, what it offers, what is best for their family.

As we continue our debate on health care, we must remain focused on solutions with outcomes. Public reporting works. Senator PRYOR's amendment ensures that customers are able to voice their approval or disapproval of plans offered by insurance companies and that information will be available to small businesses and individuals to make well-informed decisions about their health care.

How can they make a well-informed decision without knowing what plans are good, what plans are bad, what plans offer? That is why we need this, if we want to make this private market solution work for consumers.

As the experience in Minnesota has shown, public reporting also has the ability to improve quality as well. HealthScores in Minnesota has forced health plans, medical groups, and employers to focus on a common set of goals. Through this process, patient outcomes have produced dramatic improvements for chronic conditions such as diabetes.

We know already that small businesses are paying too much—up to 18 percent more than large businesses—often forcing small businesses to lay off employees or cut back on their coverage. We all know, from the letters we have gotten in our offices, what the average American families are facing right now with these skyrocketing premiums.

We must provide these patients and these consumers with tools to make informed health care decisions. Not only will we put consumers in the driver's seat so they can make the decision, we will also have an effect on the entire market. Because if insurance companies think no one is watching them, that consumers can't figure it out—maybe something has a great name so they go buy it—they will never get the kind of accountability and cost reductions we want.

The lessons from Minnesota have shown that providing consumers with information about their health care has the ability to improve patient satisfaction and drive our system to focus on quality results.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, I ask unanimous consent to proceed as in morning business, not to exceed 10 minutes.

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

Mr. BENNETT. Mr. President, in this morning's Washington Post, we have, once again, an outstanding article by Robert Samuelson, this one entitled: ''Health-care Nation: Medical spending threatens everything else.'' Mr. Samuelson has been critical of Republicans—and he is in this article—and he has been critical of Democrats—and he is in this article—but he makes some points I think are worth bringing to our attention, the primary one being that we are not focusing on the right issue, which is making some kind of attempt to turn the cost curve down—using the budgetary doublespeak—with respect to health care.

Let me quote a few comments from Mr. Samuelson's presentation. He says, first:

> The most obvious characteristic of health spending is that government can't control it.

As demonstrated by our past history, that is a very true statement, which I will show in a moment. He goes on to say:

> [The] consequence is a slow, steady, and largely invisible degradation of other public and private goals. Historian Niall Ferguson, writing recently in Newsweek, argued that the huge Federal debt threatens America's global power by an ''inexorable reduction in the resources'' for the military. Ferguson got it half right. The real threat is not the debt but burgeoning health spending that, even if the budget were balanced, would press on everything else. ''Everything else'' includes universities, roads, research, parks, courts, border protection, and—because similar pressures operate on States through Medicaid—schools, police, trash collection and libraries. Higher health spending similarly weakens families' ability to raise children, because it reduces households' discretionary income either through steeper taxes or lower take-home pay, as higher employee-paid premiums squeeze salaries.

He concludes:

> . . . Obama talks hypocritically about restraining deficits and controlling health costs while his program would increase spending and worsen the budget outlook. Democrats congratulate themselves on caring for the uninsured—who already receive much care—while avoiding any major overhaul of the delivery system. The resulting society discriminates against the young and increasingly assigns economic resources and political choice to an unrestrained medical-industrial complex.

Mr. President, I ask unanimous consent to have printed in the RECORD the entire article at the conclusion of my remarks.

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

(See exhibit 1.)

Mr. BENNETT. To demonstrate the accuracy of what Mr. Samuelson has to say, I have some charts. This one shows the breakdown of Federal spending in 1966. Why do I pick 1966? Because that was the year for the beginning of Medicare. At that time, 26 percent of the Federal budget went for mandatory spending—overwhelmingly Social Security—7 percent went to pay interest on the national debt, and 44 percent went for defense, with 23 percent for nondefense.

Where are we now? In 2008, mandatory spending had more than doubled and had gone to 54 percent, interest costs remained about the same—8 percent—defense had shrunk to 21 percent, cut in half, and the nondefense discretionary, 17. The difference? Medicare and Medicaid taking over the mandatory side.

What do we see as we look out to 2019. We can't break down the difference between defense and nondefense because that would require an analysis that is not available to us in that future year. But mandatory by that time will have grown to 61 percent. The size of the debt increasing costs now, interest costs have grown to 10 percent and defense and nondefense discretionary have shrunk to 29—a complete reversal. That is roughly what mandatory was when Medicare was started.

I am not saying we should not have Medicare, and I am not saying we should not have Medicaid, but I am saying we should be focusing on how we make people healthier, how we reward people for not using the system, how we do something to control the costs, instead of increasing the status quo with respect to health care spending.

This chart was drawn up before we had the bill before us. I think it is very likely, if the bill before us passes, this mandatory will grow even further and we find ourselves in this situation with respect to 2010. I watched the budget as it came down and it said, in 2010, Federal revenues were going to be $2.2 trillion and mandatory spending was going to be $2.2 trillion, which means every dime of everything else had to be borrowed.

I worked with Senator WYDEN and a number of others on both sides of the aisle to craft a health care plan that would turn the cost curve for health care down. We didn't even get a vote in the Finance Committee. We didn't even get anybody to consider what we had to say because everyone was focused entirely on the issue of let's cover the uninsured. The position is: Let's cover the uninsured by taking what we are doing now and spreading it even wider.

As Mr. Samuelson says, very clearly, in his column today: That squeezes out the money for everything else. That is an uncontrolled expenditure. We are not focusing on changing the system in a way that can cause cost curves to come down, we are focusing on taking the present system and spreading it wider.

The cost curve can come down. I have quoted this before. The Dartmouth study talks about where the best health care is available in America, and it is in three cities, according to Dartmouth: Seattle, WA, Rochester, MN, and Salt Lake City, UT. Then they go on to say, if every American got his or her health care in Salt Lake City, UT, it would be the best in the country and one-third cheaper than the national average. It is one-third cheaper than the national average because the focus in that plan, as it is in Rochester, MN, at the Mayo Clinic, and other places, is trying to make health care better and, therefore, cheaper, instead of focusing on taking the present system and perpetuating it.

If we don't get into that mentality, if we just take the present system, which this bill does, and spread it over a wider number of people, which this bill does, we will see the spending go up and we will see everything else suffer as a result of it and the health care will not get any better for the people who are involved.

EXHIBIT 1

[From the Washington Post, Dec. 7, 2009]

HEALTH-CARE NATION

(By Robert J. Samuelson)

President Obama's critics sometimes say that he is engineering a government takeover of health care or even introducing ''socialized medicine'' into America. These allegations are wildly overblown. Government already dominates health care, one-sixth of the economy. It pays directly or indirectly for roughly half of all health costs. Medicine is pervasively regulated, from drug approvals to nursing-home rules. There is no ''free market'' in health care.

What's happening is the reverse, which is more interesting and alarming: Health care is taking over government. Consider: In 1980, the federal government spent $65 billion on health care; that was 11 percent of all its spending. By 2008, health outlays had grown to $752 billion—25 percent of the total, one dollar in four.

Even without new legislation, the health share would grow, as an aging population uses more Medicare (insurance for the elderly) and Medicaid (the joint federal-state insurance for the poor, including the very poor elderly). Obama would magnify the trend by expanding Medicaid and providing new subsidies for private insurance. Thirty million or more Americans would receive coverage.

All this is transforming politics and society. The most obvious characteristic of health spending is that government can't control it. The reason is public opinion. We all want the best health care for ourselves and loved ones; that's natural and seems morally compelling. Unfortunately, what we all want as individuals may harm us as a nation. Our concern sanctions open-ended and ineffective health spending, because everyone believes that cost controls are heartless and illegitimate. The recent furor over proposals to reduce mammogram screenings captures the popular feeling.

The consequence is a slow, steady and largely invisible degradation of other public and private goals. Historian Niall Ferguson, writing recently in Newsweek, argued that the huge federal debt threatens America's global power by an ''inexorable reduction in the resources'' for the military. Ferguson got it half right. The real threat is not the debt but burgeoning health spending that, even if the budget were balanced, would press on everything else.

''Everything else'' includes universities, roads, research, parks, courts, border protection and—because similar pressures operate on states through Medicaid—schools, police, trash collection and libraries. Higher health spending similarly weakens families' ability to raise children, because it reduces households' discretionary income either through steeper taxes or lower take-home pay, as higher employer-paid premiums squeeze salaries.

A society that passively accepts constant increases in health spending endorses some explicit, if poorly understood, forms of income redistribution. The young transfer to the elderly, because about half of all health spending goes for those 55 and over. Unless taxes are increased disproportionately for older Americans (and just the opposite is true), they are subsidized by the young. More and more resources also go to a small sliver of the population: In 2006, the sickest 5 percent of Americans accounted for 48 percent of health spending.

Political power in this system shifts. It flows to groups that promote and defend more health spending—AARP, the lobby for Americans 50 and over, and also provider organizations such as the American Medical Association (AMA), which represents doctors. Predictably, AARP has been active in the present debate. It claims to have participated in 649 town-hall and other meetings and to have reached more than 50 million people through ads this year. Not surprisingly, AARP and the AMA recently conducted a joint TV ad campaign.

The rise of health-care nation has confounded America's political and intellectual leaders, of both left and right. No one wants to appear unfeeling by denying anyone treatment that seems needed; no one wants to endorse openly meddling with doctors' independence. It's easier to perpetuate and enlarge the status quo than to undertake the difficult job of restructuring the health-care system to provide better and less costly care.

Obama's health-care proposals may be undesirable (they are), but it's mindless to oppose them—as many Republicans do—by screaming that they'll lead to ''rationing.'' Almost everything in society is ''rationed,'' either by price (if you can't afford it, you can't buy it) or explicit political decisions (school boards have budgets). Health care is an exception; it enjoys an open tab. The central political problem of health-care nation is to find effective and acceptable ways to limit medical spending.

Democrats are no better. Obama talks hypocritically about restraining deficits and controlling health costs while his program would increase spending and worsen the budget outlook. Democrats congratulate themselves on caring for the uninsured—who already receive much care—while avoiding any major overhaul of the delivery system. The resulting society discriminates against the young and increasingly assigns economic resources and political choice to an unrestrained medical-industrial complex.

Mr. BENNETT. Mr. President, I see the Senator from Iowa wishes to ask me a question and I am happy to respond, but tell me how much time I have remaining. Maybe some of it will have to come off his time.

The PRESIDING OFFICER. The Senator has 2 minutes remaining.

Mr. BENNETT. In my 2 minutes remaining, unless it is a long question, I will be happy to respond to any question my friend may ask.

Mr. HARKIN. Mr. President, I would say that a lot of what Senator BENNETT says I agree with. That is why, in this bill—and I keep reminding people because it is not talked about much—there are more provisions in this bill to promote wellness and prevention than any health bill we have ever passed—ever—in the United States. There are huge investments in this bill on prevention and wellness.

I happen to think that perhaps one of the reasons Salt Lake City is so good is because people don't smoke and don't drink and that goes a long way toward providing for a healthier form of living. So I say to my friend from Utah, people talk about bending the cost curve only in terms of the spending. I think—and I sincerely believe this—the only way we are going to bend that cost curve is by pushing more of this upstream, by keeping people healthy in the first place, starting with kids and adults, community-based, clinical-based, workplace-based wellness programs.

So I ask my friend from Utah to look at that part of the bill.

Mr. BENNETT. Mr. President, if I can reclaim my 2 minutes to respond to the Senator from Iowa, I can give you data that indicates it is not just the fact there are a lot of people who don't smoke and don't drink in Utah that makes them healthier. I agree there are many things in this bill that are for wellness, and I approve of that. But the fact is, the bill does not go anywhere near far enough in this direction to change the paradigm that has created the situation we find ourselves in.

Every expert I have talked to, in the 3½ years I have immersed myself in this issue, has repeated that. They have said the only way you are going to deal with this is to do something dramatically different, which is what Senator WYDEN and I tried to do and we got the cold shoulder. All right, I understand, if you don't have the votes, you can't get anywhere. But the fact remains, we are not going to be able to afford all the things we want to do in this country, militarily and otherwise, in this cost projection that we are on with respect to health care right now.

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

The PRESIDING OFFICER. The Senator has used 10 minutes.

Mr. BENNETT. That is right; my time has gone. I will be happy to respond to the Senator from Montana, if he wants to take the time to let me.

Mr. BAUCUS. If my colleagues will allow, I ask unanimous consent for 3 minutes.

The PRESIDING OFFICER. Without objection, the Senator from Montana has 3 minutes.

Mr. BAUCUS. I understand what the Senator is saying, and like everything around here, there is a kernel of truth in almost everything. I read that Samuelson article, and what I took away from it is the guy is kind of pessimistic. There is not a lot you can do. People love health care, they want to get all the health care they want, and that is going to drive up spending.

But the main point is this. You mentioned how Intermountain and the quality of care is so good at Intermountain and the costs are down.

Mr. BENNETT. If I may, it is not just Intermountain. There are other agencies in Utah that do a good job.

Mr. BAUCUS. I was going to say, it is Intermountain, and there are many other great integrated systems. There is one in Billings, MT—the Billings Clinic. There are lots of integrated systems, and generally in these areas, in these integrated systems—which I think work quite well—a lot of the doctors are salaried, a lot of the incentives are there to focus on health care of the patient, and it is coordinated care in contrast with some other parts of the country.

In this bill, in addition to wellness and prevention, I would ask if the Senator agrees the delivery system reforms will help move health care, as it is in Intermountain and other integrated systems, to encourage coordinated care, encourage bundling, encourage these accountable care organizations and so forth. I was wondering if the Senator thinks that will help systems—clinics, doctors, hospitals, nursing homes and health care providers generally—to work better together, where there may be more salaried physicians than there are currently, but the salaried physicians I talked to at the Mayo Clinic, for example, and Kaiser and other similar places, kind of like that because they get decent salaries and they can spend their time not on paperwork but can focus on the patients.

I am sure the Senator knows all the delivery reforms that are in this that help move toward the Intermountain direction, and I would ask if he thinks that will help.

Mr. BENNETT. Responding to the question of the Senator from Montana, I am delighted there is as much of that in the bill as there is, but I still believe the basic structure of the bill is fatally flawed because it perpetuates the present system in ways that will guarantee the cost curve will continue to go up. I disagree with him about the Samuelson article. I do not think he is being overly pessimistic. I think he is being very realistic.

Mr. BAUCUS. One more moment, if I might, Mr. President.

I understand the bill that the Senator and Senator WYDEN cosponsored is basically to move us away from the employer-based system. Currently, our tax law encourages employers providing tax free health insurance and so forth. I understand the theoretical and actual problems with the current system. In fact, I earlier advocated moving in that direction, all the way to your legislation. But as you know, this town, this city, this country, this White House was not moving there, and major business was not moving in that direction. Therefore, we had to find something else. My main point is, if we can't go in that direction—you might say keep trying, but read the tea leaves. If we can't do that, at least now, isn't it better to start moving toward the integrated delivery system reforms in this bill?

Mr. BENNETT. Mr. President, I certainly hope this legislation will surprise me by producing——

Mr. BAUCUS. I hope so, too.

Mr. BENNETT. The result the Senator from Montana is hoping for.

Mr. BAUCUS. I like your answer, too. Thank you.

Mr. BENNETT. I am not going to hold my breath, however.

Mr. BAUCUS. Mr. President, I am going to yield 10 minutes—this is a jump ball, so why don't you go ahead. I yield to the Senator from Vermont.

The PRESIDING OFFICER. The Senator from Vermont is recognized for 10 minutes.

Mr. SANDERS. Mr. President, there are at least two major goals we have to achieve in health care reform and that is we have to expand access to everyone in America, and we have to control costs. We focus a lot on expanding insurance but expanding insurance is not expanding access. There are people today in America who have insurance but they do not have access. The fact is, we have 60 million people who do not have access to a physician on a regular basis and many of those people—according to recent studies, 45,000—may die because they do not get to a doctor in a timely manner. By the time they walk into the doctor's office their situation is terminal.

We need substantially improved access to health care. When we improve access, we save money because people do not go to the emergency room, they do not end up in the hospital, sicker than they otherwise would have been. We need a revolution in primary health care in America. Unless we do something and do it now, our primary health care system infrastructure is close to collapse.

We have an aging primary care workforce which is not being replaced. At a Senate hearing I chaired earlier this year, it was noted that only 2 percent of internal medicine residents were choosing primary care as their specialty. Happily, there are two Federal programs that can both assure access and control costs, and I refer to the Community Health Center Program and the National Health Service Corps. Both are well-established programs that have garnered broad bipartisan support because of their proven cost effectiveness.

What a federally qualified community health center is about—and I believe they exist in all States in this country. They have widespread support from Members of the Senate and the House of both political parties. What they are about is saying that anyone in an underserved area can walk into that facility and get health care, either

Medicaid, Medicare, private insurance, or a sliding scale—if you don't have enough money, you pay on a sliding scale basis—and low-cost prescription drugs.

This is a very successful program that now provides health care to over 20 million Americans and it is a 40-year-old program, again supported widely in the House and the Senate.

I am pleased that in the Senate bill, it recognizes the importance of both federally qualified community health centers and the National Health Service Corps. The National Health Service Corps is a long-established Federal program which says to people in medical school: We are prepared to provide debt forgiveness to you—on average, I know in Vermont, people are coming out $150,000 in debt—if you are prepared to work in primary health care in an underserved area.

In the Senate bill we recognize the importance of the federally qualified community health centers and the National Health Service Corps. In fact, our bill calls for authorization levels that, if appropriated, would enable the Community Health Centers Program to expand to every underserved area within 5 years, and would result in supporting at least 40,000 more primary care professionals in the next 10 years—doctors, nurses, dentists.

But we can and must improve the Senate bill. I favor very strongly the language in the House bill which calls for a dedicated trust fund with mandatory annual spending for community health centers and the National Health Service Corps. In other words, in the Senate we have authorized funding. The House has established a trust fund to actually pay for it. The Senate bill contains authorization levels that would be sufficient to fund a community health center in every underserved area in America and thus provide primary health care to 60 million more people by the year 2015. These are people who do not have to go into the emergency room, they don't have to go into the hospital because they are sicker than they should have been. They are going to get timely, cost-effective health care at a community health center.

Therefore, let me be very clear: I favor the language in the House bill which includes community health centers in its Public Health Investment Fund and guarantees mandatory funding for health centers totaling $12 billion over the next 5 years. This is in addition to the $2.2 billion current annual appropriation for community health centers which, it is anticipated, would also continue to be appropriated in each of the next 5 years. While this House funding level will not achieve a community health center in every underserved area, it will take us very far toward that goal, bringing primary care health services to some 40 million citizens living in underserved areas. Also in the House bill there is appropriated money to greatly expand the National Health Service Corps.

In the middle of all this discussion on health care, health insurance, let us not forget a few basic points. Sixty million Americans do not have access to a doctor. We need a revolution in primary medical care. We need to make sure we have the physicians, nurses, and dentists who are going to get out in underserved areas. The Senate bill provides authorization. The House bill provides a trust fund for community health centers and for disease prevention in general. My strong hope—and I am going to do everything I can to make sure it happens—is that the Senate adopts the House provisions.

If we are serious about providing health care to all Americans, we have to expand community health centers, we have to make sure there are primary health care doctors, dentists, nurses out there.

In addition, we need to focus on disease prevention. I know my colleague from Iowa has worked very hard on that. So we have to support the trust fund in that area.

I yield to my friend from Iowa.

Mr. HARKIN. First, I thank my friend from Vermont. There is no one who has been leading the charge longer and stronger and more fervently than the Senator from Vermont, Mr. SANDERS. I thank him for that. Obviously, we all have community health centers in our States. In Iowa they have been a godsend for so many people in rural areas who did not have access to these kinds of facilities.

I remember one time I was in Fort Dodge several years ago. They had a small free clinic there. It was in a church basement one night a week, so people could come in who didn't have insurance and couldn't get access to a doctor. They had one old dental chair there. I think every couple of weeks a dentist would come in for people. A woman had come in who had an abscessed tooth. It was hurting her so much she took a hammer and screwdriver and tried to knock her tooth out. Of course she damaged her gums. That is how desperate people get.

Because of that, I got the Fort Dodge community looking at a community health center. They now have a wonderful community health center. They have doctors there, they have nurses there, and people have access to that kind of dental care and health care.

Mr. SANDERS. Let me mention to my friend, in the State of Vermont, the poorest region of our State borders on Canada. It is called the Northeast Kingdom, in the northeast part of the State. For 30 years we have had a number of community health centers in that region. Do you know what? Amidst all of the poverty, all of the unemployment, all of the economic problems, we do not have a problem in terms of primary health care in the poorest area of the State of Vermont precisely because of these community health centers, which you indicate address dental care, which we often forget about, mental health counseling, we forget about, low-cost prescription drugs.

I look forward to working with the chairman of the HELP Committee and others to make sure we fund the kind of revolution we need in disease prevention, in primary health care, which at the end of the day improves people's health, keeps them out of the emergency room, keeps them out of the hospital, saves us money.

Study after study: Saves us money.

Mr. HARKIN. I thank the Senator again. I can't help but every time we talk about community health centers, I always have to add one thing. A lot of people think community health centers are just for poor people who do not have anything. Nothing could be further from the truth. They will take anyone who walks in the door. You can have health insurance, you can be on Medicare, you can be on Medicaid, you can have no insurance, you can have a great insurance plan—whoever walks in the door. They have a sliding scale based on income, based on resources, of who they will take.

It has been my experience—I ask the Senator from Vermont what it has been in his area, but it has been my experience in our growing number of community health centers in my State of Iowa that more and more people——

Mr. SANDERS. I ask unanimous consent for 2 minutes more.

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

Mr. HARKIN. Come to community health centers. Why? Because they get the kind of hands-on care, they get many kinds of supportive services. A lot of times there are language barriers that are a problem. They get preventive care, they get all the things that make people feel better about their own quality of health care. So more and more we are finding people who actually have health insurance going to community health centers.

I ask if that has been the experience in Vermont?

Mr. SANDERS. Let me concur. In the State of Vermont we have gone from 2 to 8 with 40 satellites. Over 100,000 people in Vermont are now accessing community health centers for their primary health care.

The other point we don't often make about community health centers is they are democratically run, they are run by the communities themselves. My experience is exactly that of the Senator from Iowa. They are community health centers.

In rural areas it is not rich or poor. By and large, most of the people, regardless of income, go there. The doctors are there for a long time. The dentists are there. It is, in fact, in the best sense of the word, a community health center open and accessed by all people. People take responsibility for it because it is democratically run. It is a program—one of the bright shining stars of public health in America. I hope to work with the chairman of the HELP Committee to make sure these

programs are funded adequately in this bill and that we adopt the language in the House, which goes a long way.

I yield the floor.

Mr. HARKIN. I can assure my friend from Vermont that this Senator will be in the forefront of fighting for the maximum possible support, money, and input for community health centers that we can possibly get out of this bill. I can assure him that.

Mr. SANDERS. I thank the Senator very much and yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I yield myself as much time as I might need out of the remaining time we have.

I, too, thank the Senator from Vermont for his passionate comments on community health centers. In Wyoming we have community health centers and they serve a great role. For underserved areas across the Nation, they are absolutely critical. I wish there were more that we were doing in the area of community health centers. I think it provides some better solutions than some of the other things we are doing in this bill.

Wyoming is considered to be underserved. The whole State is underserved. Even our biggest cities are considered underserved. We are missing every single kind of medical provider, including veterinarians.

Usually when I make that comment, people say: People don't use veterinarians. But as far as our distances are, some people are happy to get to a veterinarian in an emergency situation.

We do have situations across the country that need to be taken care of. One of my concerns is that we are doing this huge Medicaid expansion. And when we do the Medicaid expansion, we already have it priced for doctors so that 60 percent of the doctors won't take a Medicaid patient. If you can't see a doctor, you don't have insurance, period. I don't think we are doing enough to take care of that difficulty prior to expanding this population. So we are going to shove more and more people out of getting any health care.

AMENDMENT NO. 2942

But the main thing I wanted to do today is rise in support of the Gregg amendment which would prevent Medicare cuts in the Reid bill from being used to create new entitlement programs to cover the uninsured. Yes, I want to have the uninsured covered. I don't oppose covering the uninsured, nor do I oppose reforming the Medicare Program. We need to do those things. We absolutely need to do those. But we shouldn't do it on a system that is going broke. We should not take the money from a system that is going broke to do new entitlement programs.

I know the Senator from Montana admitted that if the Gregg amendment were to pass, it would limit some of these entitlements, that they wouldn't be able to do them. Again, we are not opposed to doing those new entitlements. We are opposed to paying for them with Medicare money because Medicare is going broke.

They do say that if we put these extra burdens on Medicare, we will extend the life of it. And you can believe that or not. But we could expand it even more and we could solve some problems in Medicare if we took the money and we used it for Medicare. Medicare needs changes. Medicare needs to have money that we are now going to move away and put into other programs. But don't worry about it because we are going to form a Medicare Commission. Every year, that Commission is going to tell us what we ought to do to make more cuts. Before we start doing more cuts, maybe we ought to make sure the cuts we are doing go to what we anticipated needed the most help.

I am not opposed to covering the uninsured. I don't oppose reforming the Medicare Program. We should do those things. What I oppose is the Reid bill. This is the wrong approach to solve the problems.

The Gregg amendment would go quite a ways to solving some of my discontent with the bill. The amendment offered by my friend from New Hampshire highlights the main problems of the Reid bill and suggests a better approach. His amendment would protect the savings from the Medicare Program and prevent them from being used to create a new entitlement. This would mean this new program would not have to rely on cuts to Medicare to fund its operation. It would also reserve all money taken from Medicare so that it could be used to fix the problems in the Medicare system.

Earlier, we had an amendment that said that the money for Medicare would go to Medicare. Every single program that we allocate money to, we have inspectors general who are supposed to make sure the money for that program goes to that program. But this is a different situation. What we are saying here is that we want the money from Medicare to go to Medicare, not the money for Medicare to go to Medicare. The money for Medicare has to go to Medicare. But we are going to take money from Medicare. I say, if we have that money we can take from Medicare, we ought to put it to Medicare and only to Medicare until we have the Medicare problem solved. Our seniors are relying on that. Don't be caught up by the little words in do-nothing amendments that say the money for Medicare is going to go to Medicare. What we want to say is that the money from Medicare goes only to Medicare.

Mr. BAUCUS. Will the Senator yield on that point?

Mr. ENZI. I am on my time here.

Mr. BAUCUS. Do we have any time remaining on our side, Mr. President?

The PRESIDING OFFICER. There are 12 minutes remaining on the majority side and 14 minutes remaining on the Republican side.

Mr. BAUCUS. I will take 2 minutes from our side to ask a question.

The PRESIDING OFFICER. Does the Senator from Wyoming wish to yield time?

Mr. ENZI. It is my understanding that the Senator from Montana is willing to take his time for the question.

Mr. BAUCUS. Correct.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. May I ask the Senator from Wyoming a question? To, from, for—isn't the result the same? If we take a program—let's take home health care. We are all for home health care. But if there is fraud, if the GAO says there is fraud in home health—maybe others too—doesn't the Senator think it is a good idea that we eliminate some of the fraud that might exist in the Medicare Program? Does the Senator agree with that?

Mr. ENZI. Absolutely.

Mr. BAUCUS. Does the Senator also agree that when that happens, that means that program—say, home health care, for example—is spending fewer dollars not on less care but fewer dollars because it is not making fraudulent payments?

Mr. ENZI. Yes.

Mr. BAUCUS. Does the Senator further agree that would extend the life of the trust fund because that program—in this case, home health—would be spending fewer dollars even though the quality of health care is not diminished? Doesn't that have the effect of extending the quality of health care, and isn't that reduction for Medicare, for seniors, not to take it away but to give it to seniors because it extends the life of the trust fund?

Mr. ENZI. That is where the Senator runs into a dead end. If you take the money that would be from home health care and you put it into an entitlement that has nothing to do with home health care, nothing to do with Medicare, then you did not extend the life of Medicare.

Mr. BAUCUS. No, no, no. There is less spending; therefore, by definition, the solvency of the trust fund is extended, so there are more dollars for seniors in future years. That is the basic point here. That is not a dead end. That is a big wide avenue to help extend the solvency of the Medicare trust fund.

Mr. ENZI. Reclaiming my time, I am the accountant in the Senate. If you take money from a program and you give it to something else, you have less money in that program. We admit that Medicare does have problems in the long term. Seven or eight years out there, it is going broke, and maybe we can extend it a year or two. If we took that money, that fraud and abuse—and I will say some more things about fraud and abuse here in just a minute—if we took that money and put it into the Medicare Program to extend the life of the program, we could give some assurance to seniors that we are doing something for them. That is where a lot of the concern comes from.

On fraud and abuse, if there is all this fraud and abuse out there, how

come we haven't been getting at that in the past and putting it to some kind of good use? All of a sudden, we are saying there is all this fraud and abuse and we are going to take this extra fraud and abuse and we are going to put it in there. I notice we have increased the amount of fraud and abuse we are capturing, but we did that by changing the definition. We just claimed more fraud and abuse. We didn't capture more money. That is one of the problems with having a government bureaucracy do things they really have no value in doing. If the government agency finds the money, it doesn't come back to their program, so they are not very excited about doing it. We keep passing fraud and abuse things around here, and the fraud and abuse never gets found to any extent. And the money can't be used if it can't be found.

As an accountant, what I have always suggested is, we have a separate fund set up, and when we find this fraud and abuse, we put it in that fund. We would only be able to use the money from that fund in these areas where we say we are going to fund it with fraud and abuse money. Because we have no incentive in government to go out and collect the money. It is a huge problem around here.

Some Democrats have argued that we are not creating a new entitlement program. They are simply wrong with that too. Just like Social Security, Medicare, and Medicaid, this bill will commit the Federal Treasury to paying for these new subsidies for the uninsured forever.

When we start a program around here, we don't put an end date on it. As soon as we have passed it, the people say: Wow, thanks, that is really great. Now what are you going to do for us? We look around and we say: Maybe we can do like Medicare Part D. Then we pass that and they say: Yes, you gave us Medicare Part D, but you still have the doughnut hole. So we take care of that. Anytime we do an entitlement, we keep adding to the entitlement regardless of where the money is coming from. And that is how Medicare has gotten in trouble. Once subsidies are given, they are never taken back. They are only expanded. There is no appreciation for what has been done. Medicare Part D; now they want the doughnut hole closed.

We are going to do kind of a phony thing to close that doughnut hole. PhRMA said they would give $50 billion that can be used as a subsidy as people go through the doughnut hole, but they said: You can only use the subsidy if we can pay it directly to the customer. That way, they keep in contact with the customer. And you can only use it if they stay with our brand name. OK, so they get through the doughnut hole. Then the taxpayer picks up the money, and they are stuck with the brand name. That is why the pharmaceutical companies can make so much money. If they can get them to not switch to that generic and make good economic decisions as they go through the doughnut hole, they can make a lot more money, once it is on the taxpayer outside of the doughnut hole. I am really upset with the pharmaceutical industry for doing that. That is the reason they are putting all the money into promoting this.

That means that as Federal spending continues to grow, new programs continue to grow. It will crowd out other Federal spending priorities such as education or national defense. States will tell you it is already crowding out education. When we put these new Medicaid requirements in there and they have to pay for them, they have a limited budget too. What they have done is take money away from colleges, so colleges have had to increase tuition dramatically in order to cover the money they had to give to Medicaid. So when we do some of these things, we are affecting a whole lot of things, other spending priorities such as education and national defense.

Any future attempts to modify or restrain this growth will be met by cries of indignation, arguing that cuts would devastate access to health care. If anyone has any doubt, they should look at the transcripts from our debate on the Deficit Reduction Act.

In 2005, Congress tried to reduce Medicare spending by about $20 billion and enact modest reforms to the Medicare Program. These reforms would have strengthened the long-term solvency of these programs which we are talking about now and helped reduce the Federal deficit. In response, Senator REID called that bill an ''immoral document,'' and the junior Senator from California said she strongly opposed the cuts in the bill because they would ''cut Medicare and Medicaid by $27 billion.''

There are thousands of media quotes. The media quotes the majority more often, and here in DC the volume of quotes is equated with being right. Yet today these same Members and the rest of my Democratic colleagues want to create a new entitlement program that will spend hundreds of billions of dollars, and they would pay for it by cutting $464 billion from the Medicare Program. That is enough money to run the State of Wyoming for 320 years.

We don't understand how much money we are talking about here. You can't take that kind of money from a program, give it to other programs, and expect the program to work. We recognize that. That is why we put this Medicare Commission in there that annually is supposed to suggest extra cuts.

Let's see. We made a deal with the hospitals that we weren't going to cut them. We made a deal with the pharmaceuticals that we wouldn't cut them any more. We made a deal with doctors that we wouldn't cut them any more, although we never followed through on the doctor stuff because their deal—and these were all hidden deals—was supposed to be that they would either get a 1-year fix on the doc fix and medical malpractice or they would get a 10-year fix on the doc fix. That isn't in either of the bills. I don't know if they are going to stick with the hidden deal they made. I don't know what other hidden deals there were in this.

I believe these facts highlight why we need to adopt the Gregg amendment.

We should be very careful creating a new entitlement program which will permanently obligate our children and grandchildren to pay its costs. In fact, with the way we have maxed out our credit cards, we are now talking about the seniors actually having to pay for these other new entitlements. So grandpa and grandma will be paying for that, too, not just our grandkids and children. If my colleagues insist on doing it, however, at a minimum we need to guarantee that any new program has a stable and reliable source of funding. The Medicare cuts in this bill are neither stable nor reliable.

My Democratic colleagues have spoken at length about how the Medicare provisions in this bill will bend the growth of health care spending. That, unfortunately, is far from accurate. If you don't believe me, listen to what the other nationally recognized experts have to say.

According to the New York Times, the CEO of the world-renowned Mayo Clinic, which we use around here all the time, dismissed the reforms in the bill. Dennis Cortese said the Reid bill only took baby steps toward revamping the current fee-for-service system. The dean of the Harvard Medical School, Jeffrey Flier, said the bills being considered in Congress would accelerate national health care spending.

I wish there were more actual reforms in this bill. I applaud some of the efforts Senator BAUCUS included that will create incentives for coordinated care and rewarding providers who provide higher quality. I believe those are exactly the types of things we should do to improve the Medicare Program. Unfortunately, the savings from these actual reforms are a few pennies compared to the dollars of the arbitrary payment cuts included in the bill.

According to the Congressional Budget Office, all of the savings from the various policies to link Medicare payments to quality and encourage better coordination of care in the Reid bill provide less than $20 billion in total savings.

In contrast, the Reid bill includes over $220 billion in arbitrary payment cuts to health care providers, including hospitals, nursing homes, home health agencies, and hospice providers. We have made a point of how much those are and what the effect is going to be, and it is going to take away service that people have come to expect.

The Reid bill also includes an additional $120 billion in cuts to Medicare Advantage plans. Medicare Advantage is—we talked about wanting to provide catastrophic care for everybody. That

was one of the goals. Well, Medicare people do not have catastrophic care. They can buy catastrophic care through Medicare Advantage. But we are talking about making some substantial cuts to that which are either going to decrease benefits or, in some cases, make the whole service go away.

Those are not reforms. Instead, they represent the best efforts of folks in Washington to guess how much it actually costs real doctors and nurses to provide health care services to Medicare beneficiaries. We are not experts in the health care field, but we are going to guess at how much extra revenue they are getting. I want to emphasize that word ''revenue'' because, again, as an accountant, there is a difference between profit and revenue. We are going to cut substantially into the revenues, which is going to eliminate profits, which is the point at which people say: Why am I doing this?

So doctors and nurses are going to—people who are looking at being doctors and nurses are going to say: Why would I want to do that? Well, there is going to be a huge demand because the baby boomers are coming up, and they are going to need services.

So cuts like the ones to doctors and nurses and home health, and all of those, are an excellent example of how government price controls do not work.

Medicare does not negotiate payment rates with providers like private insurers do. Medicare uses price controls to set payment rates.

When I first went into the shoe business, President Nixon suggested we should have price controls; that the cost of goods was going out of sight. At that time, one could buy a pair of men's dress shoes for $10. They put in price controls—like this—but they could not put the price controls in immediately because it takes a while to pass a bill. So what did everybody who was manufacturing shoes do? They raised their prices, which forced us at the retail end to have to raise our prices too. By the time that went into effect, that $10 pair of shoes was $20. So price controls do not work. I have experienced it. It was dramatic, and it was terrible for the customer. We are talking about customers again.

Medicare uses price controls to set payment rates. Experts in Washington then look at various reported costs, revenues, and profits of health care providers, and then decide how much we should pay health care providers.

I have often said everyone thinks they know everything about a business until they actually have to run it. Unfortunately, we have been taking over a lot of businesses, and our expertise is showing. I am kind of fascinated by the Cash for Clunkers. That was a little business we decided we would set up on behalf of the government, and we said it would last for 4 months. It went broke in 4 days.

So as to any of the numbers anybody around here is considering, you ought to take a look at it because as a former small business owner, I want to assure them, it is actually a lot harder to run a business than it looks. For the simplest business you can think of out there, if you scratch the surface just a little bit you will find out those people are making dramatic decisions on a daily basis just to keep in business, which means, hopefully, paying themselves, but definitely paying their employees because that is not an option. If it was as easy as we think around here to do a business, everybody would be going into business.

The Medicare cuts in this bill are based on the efforts of folks in Washington to decide how much it costs to run a nursing home in Cheyenne or a home health agency in Gillette or any of these businesses in much smaller communities than that. Based on the past track record of Washington, I do not have much confidence in their abilities, and I do not think America does. I think that is showing up in the polls. I think that is showing up in the town meetings.

In 1997, Congress passed the Balanced Budget Act. It contained Medicare payment cuts. Lots of smart folks in Washington made arguments similar to those we are hearing today about how those cuts would not harm the providers or beneficiaries. That was historic.

Well, let me show you the historic arrogance of that time. What happened after these cuts went into effect? Within 2 years, these cuts had driven four of the largest nursing home chains in the Nation into bankruptcy. Vencor, Sun Healthcare, Integrated Health Services, and Mariner Post-Acute Network all filed for bankruptcy. Between them, they operated 1,400 nursing homes that provided care for hundreds of thousands of Medicare beneficiaries.

Similarly, the bill also included cuts in payments to Medicare+Choice plans. After these cuts went into effect, one out of every four plans pulled out of the Medicare program. Millions of beneficiaries lost the extra benefits these plans had provided.

Given this track record, I have grave concerns about what the Medicare cuts in the Reid bill would do to Medicare beneficiaries and the doctors, hospitals, and other providers who treat them. I have even greater concerns about using any estimated savings from these cuts to fund this new entitlement program for the uninsured.

That is why we should pass the Gregg amendment. Rather than relying on cuts that could devastate the Medicare Program, let's find a stable and reliable funding source that we could use to pay for health care reform. The Gregg amendment says that savings from any Medicare cuts should be reserved for the Medicare Program. That way, if the Washington experts again got it wrong, we will not have already spent all the savings on another program.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. ENZI. Madam President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Madam President, I ask unanimous consent that the time until 1 p.m. today be under the same conditions and limitations as previously ordered; further, that the prohibition on amendments and motions also be extended until 1 p.m.

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

Mr. BAUCUS. Madam President, I yield 25 minutes to the Senator from North Dakota.

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

Mr. CONRAD. Madam President, I thank the distinguished chairman and I thank the Acting President pro tempore.

I come to the floor to respond to some of the things I have heard over the last several days with respect to the legislation before us and to try to give—in some cases—the other side of this story because I am increasingly concerned, as I listen to this debate, that people have started to create their own facts, and that is never useful in a debate.

Let me start with an ad that is running—a full-page ad—back in my home State of North Dakota, with the headline:

Isn't Senator Conrad Supposed to be a ''Deficit Hawk?''

It starts by saying some nice things about me. It says:

Senator Kent Conrad has a long, admirable record as a deficit hawk. For years, he has advocated for fiscal sanity and smaller deficits, and he has served North Dakota well.

I wish they would have just ended the ad there. That would have been a very good ad. But they go on to say:

Now, federal spending is totally out of control:

And they give some examples. Then they say:

On top of all this, Congress is considering a new $900 billion health care entitlement, with some estimates saying it could actually cost more than $2 trillion!

Well, the $2 trillion number is a number that somebody has concocted. That is not the 10-year cost of this bill. The 10-year cost of this bill is between $800 billion and $900 billion, as the ad says. Then they go on to conclude:

America can't afford it. And North Dakotans can't afford it.

Of course, this ad is not paid for by North Dakotans. But they are clear that: ''North Dakotans can't afford it.''

Senator Conrad: how can you even consider this?

''How can you even consider this?'' Well, because I have read the bill, and this bill does not increase the deficit; this bill reduces the deficit. That is not my opinion as chairman of the Budget Committee. That is what the Congressional Budget Office—which is nonpartisan, which is the objective scorekeeper—they are the ones we look to

for analysis of legislation before Congress. Objective analysis—not made up analysis. Here is their conclusion.

This is the Congressional Budget Office estimate of the Senate health plan, the legislation that is before us now. It reduces the deficit over the budget period by $130 billion. It does not increase the deficit, despite all the speeches that have been given. It reduces the deficit by $130 billion.

Our colleagues get different numbers because they come out here and say: Well, if this part of the bill were not included, it would increase the deficit. But that is not the bill. The bill before us has been analyzed by the Congressional Budget Office, and they say the bill before us—the one we will be voting on—reduces the deficit by $130 billion in the first budget window.

In the second budget window—the second 10 years—the Congressional Budget Office says:

> CBO expects that the bill, if enacted, would reduce federal budget deficits over the ensuing decade [beyond 2019] relative to those projected under current law—with a total effect during that decade that is in a broad range around one-quarter percent of [gross domestic product].

What is one-quarter of 1 percent of gross domestic product in the second decade? It is $650 billion. If you take, then, in total what the Congressional Budget Office is telling us to 2019—the first 10 years—it reduces the deficit by $130 billion. In the second 10 years, it reduces the deficit by one-quarter of 1 percent of GDP, which is equal to $650 billion.

So to my friends who ran this ad in every newspaper in my State, wondering why a deficit hawk might support this legislation, it is because this legislation reduces the deficit, both in the first 10 years and in the second 10 years, according to the Congressional Budget Office. That record should be clear.

Do we have a problem long term? Absolutely, we do. As this chart shows, Medicare and Medicaid combined are going from 2 percent of GDP, back in 1980, to 12.7 percent of GDP on the current trend line by 2050, and that is an unsustainable course. I think we all understand that. Medicare and Medicaid are increasing very dramatically as a share of our gross domestic product, and they are a key reason we are seeing the gross Federal deficit expand, and expand dramatically.

We now project the gross Federal debt to be 114 percent of the gross domestic product in 2019. That is almost as high as it was after World War II, which is the previous record in this country. Already we are approaching 100 percent of GDP with the economic downturn and with all the pressures that exist with two wars and a very sharp reduction in revenue in this country.

The reality is, for those who say we do not have to do anything, Medicare is going broke. It is already cash negative; that is, more money is going out from Medicare than is coming in under the revenue sources of Medicare. The trustees tell us it will be insolvent by 2017—2 years earlier than forecast just last year.

So those who say we do not have to do anything—just steady as she goes, the status quo is fine—are detached from any financial reality. The bill before us has significant Medicare savings: provisions that lower cost growth without harming beneficiaries.

Let me give some examples. In the legislation before us, we reduce overpayments to private Medicare Advantage plans. We reform the health care delivery system. By the way, this is the provision that most experts say is the single most important component of this legislation, and it has gotten almost no attention in this debate. It has gotten almost no attention in the media—reforming the delivery system so instead of paying for procedures, we pay for quality outcomes.

We incentivize those integrated systems such as the Mayo Clinic, such as the Cleveland Clinic, such as Geisinger in Pennsylvania and Intermountain Healthcare out in Utah that have much lower cost and the highest quality outcomes. We are going to, for the first time, provide major incentives for other systems to adopt their good practices. This is what health care reformers say are really the most important parts of the legislation.

We also improve payment accuracy, crack down on fraud and waste, which we all know is significant in Medicare, perhaps as much as $70 billion a year. We are going to beef up very substantially the moves to go after those who are committing fraud in this system. It also slows the growth in reimbursements to providers, many of whom will benefit from over 30 million newly insured people.

So people ask: How is this bill paid for? One of the biggest ways of paying for it is to go to the providers and say: Your future increases will not be as large as previously indicated. You are not going to have growth as much as you had previously thought in your level of reimbursements. These groups have, by and large, agreed to that prospect. Why? Because, No. 1, they know there are savings to be accrued. No. 2, they know that with over 30 million more people being covered, they will have a big increase in business, and they will have a sharp reduction in uncompensated care.

So that is why the hospitals have agreed to more than $150 billion in savings over ten years and that is why nursing homes and home health care have agreed to significant savings and why the pharmaceutical industry has as well. Let me say, before we are done, I believe that what is in the bill for nursing homes will be further modified so it is not as much of a reduction in their increases as was anticipated. Because if you look at who has put up how much, there is rough agreement from these providers to take these reductions in their increases. They are not cuts in the sense of getting less next year than they got the year before, it is getting less of an increase.

Interestingly enough, an argument made by Republicans when they were advocating reductions and savings out of Medicare were far higher, far bigger than anything that is in this bill. This is an amusing point for those who have been listening to this debate. Our Republican colleagues are now decrying savings out of Medicare which just a year ago they themselves were advocating. They had their President come forward with a proposal with much bigger savings than those in this bill. We will get to that in a minute.

Here is what some of my colleagues have been saying on deficit and debt because the rhetoric coming from our colleagues on the other side has been interesting, and the difference between their rhetoric and their amendments is striking. Here is what they have said. This is Senator MCCONNELL, the Republican leader:

> We're heading down a dangerous road. It's long past time for the administration and its allies in Congress to face the hard choices that Americans have had to face over the past several months. No more spending money we don't have on things we don't need. No more debt.

That is Leader MCCONNELL.

Senator KYL, again, a member of the Republican leadership:

> We have got to reduce deficit spending to manageable levels and ultimately learn to live within our means, and the sooner the better.

Senator MCCAIN, who offered the first Republican amendment:

> This staggering deficit threatens our children's and grandchildren's future and simply cannot be sustained. I call on my colleagues on both sides of the aisle to chart a different course toward real change and fiscal responsibility.

Well, that is what they have said in their speeches. What have they done with their amendments with respect to debt? This is curious. Every major amendment they have offered was to increase the debt, to increase deficits. After all the brave speeches about how important it was to be fiscally responsible, what amendments have they offered? Well, Senator MCCAIN offered the first one to eliminate the Medicare savings. That would increase the deficit and increase the debt by $441 billion. So much for the brave speeches.

The Hatch amendment was to continue overpayments to Medicare Advantage plans, increasing the deficit and debt by $120 billion. So much for the brave speeches.

The Johanns amendment to eliminate the home health care savings would increase the deficit and debt by $42 billion.

So far our Republican colleagues, who have given such strong speeches about the need to reduce deficits and debt, every single major amendment they have offered have been to increase deficits and debt and so far the running

total is over $440 billion that our colleagues on the other side would increase the deficit and debt by, if their amendments had been adopted.

The good thing is, there are other people watching, other people who are listening to the speeches and comparing the speeches to the amendments and comparing the speeches to the policy prescriptions of our colleagues on the other side. Here is what the American Association of Retired Persons said on November 20:

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

On November 18, the American Association of Retired Persons said this:

> The new Senate bill—

Talking about the bill before us—

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

The Federation of American Hospitals, on November 20, said:

> Hospitals always will stand by senior citizens.

The American Medical Association said, on that same day:

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

On November 16, the Catholic Health Association of the United States said:

> The possibility that hospitals might pull out of Medicare is very, very unfounded. Catholic hospitals would never give up on Medicare patients.

Again, from the National Committee to Preserve Social Security and Medicare on November 19:

> We are . . . very well aware of the positive impact health reform can have on the future of the Medicare program and its beneficiaries.

One of the things that is most striking to me in listening to our friends on the other side is they are trying to scare people into thinking that the savings in Medicare are going to disadvantage Medicare beneficiaries. What is most remarkable is, the last time our friends on the other side offered a budget, it was offered in the Bush administration. Their savings out of Medicare in that budget were $481 billion over 10 years, far larger than the savings in this bill. Interestingly enough, I never heard a single Republican colleague say one peep about those savings out of Medicare. There was no suggestion it threatened grandma. There was no suggestion this was going to ruin Medicare. There was no suggestion these savings out of Medicare were going to undermine Medicare beneficiaries. That was their budget. That was their President's budget, to save $481 billion out of Medicare.

Let's compare it to the savings in Medicare in this bill. The Bush administration, the last budget they offered, had $481 billion in 10-year savings out of Medicare. The net reduction in this bill is $380 billion. I would ask my colleagues on the side opposite: What is the bigger number? Is $481 billion bigger or is $380 billion bigger? They didn't say one word in opposition to Medicare savings from the previous administration, their administration, when it was $481 billion, but now this administration has savings of $380 billion on a net basis, all of a sudden the sky is falling and it is the end of the world. I would say the hypocrisy meter is on tilt when I listen to these speeches from the opposite side.

Medicare Advantage plans. I have heard so many speeches here about Medicare Advantage. Medicare Advantage was originally put in place to save money for Medicare. In fact, it was capped at 97 percent of traditional fee-for-service Medicare. What has happened? Is it saving money? No. On average, it is costing 114 percent of traditional fee-for-service Medicare. In fact, there are plans in Medicare Advantage that are costing 150 percent of traditional fee-for-service Medicare. We have a runaway train. We have a program in Medicare Advantage—at least some elements of it, to be fair, because some of them are working fine—some elements of it are a runaway deficit train, costing 150 percent of traditional fee-for-service Medicare. These are the hard realities Medicare Advantage is contributing to Medicare's fiscal problem.

This is the MedPAC report from March of 2009:

> In 2009, payments to Medicare Advantage plans continue to exceed what Medicare would spend for similar beneficiaries in traditional fee-for-service. Medicare Advantage payments per enrollee are projected to be 114 percent of comparable fee-for-service spending for 2009. . . . This added cost contributes to the worsening long-range financial sustainability of the Medicare program.

In plain English, it is contributing to Medicare heading for insolvency, and this bill does something about it. It moves Medicare Advantage to a more sound and sustainable course.

By the way, interestingly enough, the estimates by the Congressional Budget Office are, there will be more people in Medicare Advantage after this bill passes. After this bill passes, there will still be more people in Medicare Advantage than have been in the past. So Medicare Advantage will go forward, but the abuses will be run out of the system, the overpayments will be reduced, and that will help extend the solvency of Medicare.

Question: Does this bill that is before us extend the solvency of Medicare or does it reduce the years of solvency of Medicare? What is the right answer? The correct answer is, this legislation extends the solvency of Medicare by at least 4 years and perhaps 5. We know the House bill has been scored. It extends Medicare solvency, according to the CMS actuaries, 5 years. The bill that came out of the Finance Committee extended solvency of Medicare by at least 4 years, and most estimates are, the bill before us does somewhat better.

Back on the question of Medicare Advantage:

> Taxpayers pay 50 percent more for beneficiaries enrolled in Medicare Advantage plans in some areas.

I asked CBO last year: Is Medicare Advantage saving money which was its original intention? They came back and said not only is it not saving money:

> It is on average costing 14 percent more, or 114 percent of traditional fee-for-service Medicare and, in some places, the Medicare Advantage pricing benchmarks currently range from 100 percent to over 150 percent of local per capita spending in the fee-for-service traditional Medicare sector.

Facts are stubborn things. The fact is, this bill reduces the deficit by $130 billion over the first 10 years and by as much as $650 billion over the second 10 years. Those are facts, according to CBO, not facts made up by colleagues on the floor, for one purpose or another.

This bill extends the solvency of Medicare by at least 4 years and perhaps as long as 5 years. That is not all that needs to be done, but it is a beginning. Those who want to oppose it and vote against it will have to explain why they don't want to extend the solvency of Medicare, why they don't want to achieve savings, why they don't want to go after the fraud and abuse that exists in the system.

Let me say with respect to the Gregg amendment, I have enormous respect for Senator GREGG, but his amendment is designed to kill this bill.

Let's just be clear. That is the purpose of the amendment. If you want to kill the bill that reduces the deficit, the bill that will reduce premiums for a significant majority of the American people; if you want to kill the bill that begins the critically important process of reform, then you ought to vote for the Gregg amendment. If you want this bill to be able to advise and deliver on the promises made to the American people about what must be done to solve Medicare—not to solve it but to extend its solvency; if you want to have legislation that begins the critically important process of reform, then reject the Gregg amendment.

I yield the floor.

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

Mr. ENZI. Madam President, I wasn't going to take any part of this 30 minutes, but I can't help it. I will allocate myself 5 minutes.

I keep running into this comment that the Republicans were willing to cut $481 billion from Medicare. Would somebody show me where we cut $481 billion from Medicare? We didn't do it, and this bill won't cut $464 billion. Seniors won't let you do that. We didn't even propose it; the President proposed that. We knew it wasn't going to happen. You cannot cut Medicare without

having the seniors all upset because they understand their program is going broke—going broke.

That is why we have had this series of amendments. We have tried to come up with one that would actually solve the problem. We have been emphasizing the problem. The Gregg amendment takes care of the problem. That is why we brought up the Gregg amendment and why we should pass it. Rather than relying on cuts that can devastate the Medicare Program, we can find a stable and reliable funding source to pay for health care reform.

The Gregg amendment says that savings from any Medicare cuts should be reserved for the Medicare Program. That is saying that if these things are all possible that we are talking about as being possible and as being cost savers, if they really work, put it into Medicare. If you really want to extend Medicare, don't just say you are going to extend Medicare and then overlook a few things.

I have a little chart I haven't had a chance to use yet.

It was reiterated here that this bill is ''deficit neutral.'' Yes, according to CBO, it is—if you assume that Medicare physician payments will be cut 20 percent in 2011 and that they will be cut 40 percent over the next 10 years. We hold the physicians hostage every year, 1 year at a time, to get something out of them, and then we keep the cuts from happening. These cuts aren't going to happen. If they did happen, it would not be deficit neutral.

The bill makes no provision for paying this 20 percent that will be cut in 2011 or for the 40 percent over the next 10 years. There is no provision. So that part is going to be false as to having a deficit-neutral bill.

A massive new tax will be imposed on employer health benefits, hitting 31 percent of American family plans by 2019, if that does not happen—and I think people will notice the tax in a whole bunch of different ways—then this assumption is wrong and it is not deficit neutral.

Also, it relies on us cutting $464 million from Medicare. The Actuary said this level of cuts would bankrupt hospitals and threaten patient care.

I have a typo on the chart. It is supposed to be $464 billion, not million. I am still having trouble with that.

That amount would fund the State of Wyoming for 320 years. It is a big number. We are talking about cutting it by that much. If we don't cut this and we use this to pay for the other entitlement, the bill is not deficit neutral. CBO says that.

Everybody is entitled to their own opinions, but the facts are there. The facts say that if, if, if. We are not going to do those ''ifs.'' I will not go into that point, even though I am a little upset.

Mr. GREGG. Will the Senator yield for a quick question?

Mr. ENZI. Yes.

Mr. GREGG. I know the Senator from Idaho wants to speak, but if I can ask the ranking member a quick question.

Mr. CRAPO. That is fine.

Mr. GREGG. I heard the Senator from Montana and the Senator from North Dakota say the amendment I have pending would make it impossible for them, under this bill, to create their entitlement programs because the Medicare money that will be taken from Medicare would not be available. My amendment says they cannot do that. It says Medicare cannot be used to create new entitlements, but it doesn't say those entitlement programs cannot be created if they want to pay for them some other way. So really what they are saying is they don't have the idea, the courage, or the will to pay for them in a way other than by stealing from Medicare. Isn't that what they are saying?

Mr. ENZI. The Senator from New Hampshire is absolutely correct. I am glad he came here to make that point on the amendment we are going to vote on this afternoon. It is critical. If you want to save Medicare, this amendment will save Medicare. It doesn't prohibit their programs from happening. They can still do the entitlements, but they have to be sure they are paid for. That is one of the problems. To say they are going to take the $464 billion from Medicare and put it into these other entitlements, that is not fair.

Mr. GREGG. I thank the Senator.

Mr. ENZI. Madam President, I yield 10 minutes to the Senator from Idaho.

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

Mr. CRAPO. Madam President, I am here to speak in support of the Gregg amendment. I rise in support of my colleague's amendment because it would prohibit using Medicare cuts in the Democratic health care bill to pay for new government spending.

It is interesting, as you listen to the debate—in fact, I was interested to hear my colleague from North Dakota say the Republican amendments would increase the deficit. They would only do that if you assume all of the spending in the bill, which is also opposed by the Republicans.

One of the key parts of the debate that I think needs to be emphasized here is, among all of the other things this bill does, when you have the first full 10 years of real implementation of the bill, it is a $2.5 trillion increase in Federal spending, paid for with hundreds of billions—in fact, trillions in new taxes and cuts in Medicare.

The purpose of the Gregg amendment is to require that when we do achieve savings in Medicare, instead of it being used to just transfer into a new government entitlement program, making Medicare less solvent, we use the savings for Medicare itself.

In the first 10 years of their bill, we will see cuts in Medicare by $465 billion, every dollar of which will simply be transferred over to a massive new Federal entitlement program. If you actually take the first 10 full years of the implementation of the bill—and recall that there are some budget gimmicks being played to say it is not generating a deficit, and it is not really implemented fully until about 4 years into the bill—if you take the first 10 years of implementation, the cuts to Medicare are not $465 billion but $1 trillion, and $3 trillion over a longer period of time as we evaluate the bill moving into the future.

In Medicare's hospital insurance trust fund, annual outlays already exceed the annual income, so the fund is drawing down its holdings to pay full benefits—but not for long. By 2017, the HI trust fund will be insolvent and will no longer able to pay full benefits for seniors. These cuts will make it worse.

This amendment provides that the major provisions in the underlying bill, including the subsidies and Medicaid expansion, cannot go into effect unless the Director of OMB and the Centers for Medicare and Medicaid Services certify that all of the projected spending in the bill is offset with savings, but that savings shall exclude any changes to Medicare or Social Security. In other words, we require that Medicare savings be used for Medicare and Social Security savings be used for Social Security. This will ensure that the savings generated from the Medicare cuts in the bill don't go toward the creation of a new entitlement program at the expense of our seniors. If the non-Medicare savings don't offset the new costs, then the Secretary of the Treasury and the Secretary of HHS are prohibited from implementing new spending or revenue-reduction provisions in the bill.

Republicans have opposed the Reid bill's harmful cuts to Medicare through three votes. Should those cuts remain, the Gregg amendment makes sure Medicare savings go to making the program more solvent, not to offsetting the new entitlement programs.

Congress should not raid Medicare—a program that has $38 trillion in unfunded liabilities—and use it as a piggy bank to pay for a new health care entitlement. The government already has $70 trillion in unfunded obligations over the next 75 years, and we should not add to it with these dangerous provisions. The $70 trillion in unfunded obligations represents a burden of $600,000 per American household. The Reid bill carries an estimated cost of $2.5 trillion over the first 10 years that it is fully implemented. It is fully loaded with budget gimmicks.

Earlier in the debate, we voted 100 to 0 for the Bennet amendment—a rule of construction—which stated that nothing in the bill ''shall result in the reduction of guaranteed'' Medicare benefits. In contrast with the Bennet amendment, the Gregg amendment actually guarantees there will be Medicare for future generations, while guarding against the creation of a new unfunded entitlement this country cannot afford.

I wish to respond a little bit to some of the arguments my colleague from North Dakota just made.

I mentioned we have had three votes already to try to take these Medicare cuts out of the bill. All of those votes have failed. The Senator from North Dakota indicated those votes would have reduced the deficit or would have caused a huge deficit problem. That is only true if you assume the $2.5 trillion of spending in the bill will continue.

But those who claim there is a reduction in the deficit in this bill can do so only if they assume three things—one, if they assume the budget gimmicks are implemented. They have not included the SGR payments for physicians—a $245 billion cost over the next 10 years. It is just not in the bill because it cannot be accounted for.

Second, they have delayed the cost implementation portions of the bill by 4 years now, so that they have 10 years of revenue and 4 years of spending, so they can claim it balances. Even then, they cannot claim this bill helps the deficit unless they assume the hundreds of billions of dollars of new taxes and the hundreds of billions of dollars of cuts in Medicare. If any one of those items was taken out—the Medicare cuts, the tax increases, or the budget gimmicks—this bill would be shown to be what it is: a huge expansion of the Federal Government that is going to necessitate increased tax burdens and reductions in spending, as well as budget gimmicks to hide what cannot be hidden in order to claim it doesn't generate a deficit. I think most Americans understand that those kinds of gimmicks are the things we see all the time in Congress when we are trying to make it look as if we are not engaging in debt spending and increasing the national debt.

The bottom line here is that there is a significant amount of reform that can be achieved, that can reduce the cost of health care, that can reduce the cost of health insurance premiums, that we could agree to on a bipartisan basis if we were not stuck in this debate on the insistence that we create a massive new intrusion of the Federal Government into the operation and control of the health care economy and the development of another massive new Federal entitlement program at the expense of some of the current entitlement programs.

I haven't even talked about what is being done in Medicaid yet. I am sure others will talk about that.

This bill, as I said, will increase spending and the size of the government by $2.5 trillion. It will cut Medicare benefits over that same true full period by $1 trillion. It will increase taxes by hundreds of billions of dollars, and over that true full 10-year period of implementation, over $1 trillion. It will force the neediest of our uninsured in this country not into the opportunity to gain insurance coverage but into another failing entitlement program, which is Medicaid. It will drive a massive, unfunded mandate onto our States, which are already trying to figure out how they are going to deal with their fiscal problems. It will cause the cost of health insurance to go up for 30 percent of all Americans immediately and for the 70 percent who are in the large groups and get insurance from large companies, and they will basically see no significant savings and ultimately more taxes.

The bottom line is, we are not going to see an increase in the ability to control or handle the cost of health care. We are going to see an increase in government, an increase in government controls, an increase in taxes, and a reduction in the stability of our Medicare programs. That is not the way we should approach reform.

The Gregg amendment simply says let's create a lockbox, if you will, for Medicare, the same kind of lockbox we need for Social Security to keep the Congress from continuing to raid Social Security. Let's put it into place to ensure that all these great statements we hear on the floor about how we want to protect and preserve Medicare are enforced.

It simply creates by power of law, by force of law, the necessary mechanism to help all of us be sure that what we are talking about on the floor actually happens; namely, that we protect Medicare from being raided for the establishment of yet again another massive Federal entitlement program.

Madam President, I yield back my time.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. Madam President, may I inquire as to the time arrangement?

The ACTING PRESIDENT pro tempore. The minority has 5½ minutes. The majority has 7½ minutes.

Mr. BAUCUS. Madam President, before we continue, I ask unanimous consent that the time be extended for debate only until 2 p.m., with the limitations of the previous order remaining in effect.

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

The Senator from Wyoming.

Mr. ENZI. Madam President, I usually don't say much at these debates, but today I am going to make that an exception. I allocate the rest of our time to me. There have been a lot of comments here and they need to be clarified.

I do want to pass a bill that decreases health insurance premiums. I have traveled thousands of miles across the State of Wyoming, and every time I talk with somebody about health care, they ask me to do something to lower their health care costs—to lower their health care costs. That is what most people in America want.

American families cannot afford to pay ever increasing health insurance premiums. Small businesses cannot afford premiums that increase twice as fast as inflation.

Earlier this week, CBO issued—actually, it was last week—its long awaited report on the impact the Reid bill would have on insurance premiums. CBO said the premiums for individuals and families purchasing their health insurance will increase by 10 to 13 percent.

That means if the Reid bill is enacted, these folks will pay 10 to 13 percent more—more—for their health insurance. The legislation that its sponsors say is intended to lower health care costs will actually increase insurance premiums.

We should not be surprised by this finding. Several well-known actuarial business consulting firms have already issued reports that said the exact same thing: The bill increases health insurance premiums.

What is surprising is that some of my Democratic colleagues have argued that this CBO report provides support for enacting health reform. The New York Times even described this as ''Good News on Premiums.''

These statements defy logic and common sense. The bill attempts to completely restructure the nonemployer insurance market and impose massive new government mandates. Is anybody surprised that as a result the costs will go up?

Yet some of my Democratic colleagues have attempted to cherry-pick data and use selective quotes to try to mask what CBO said. For instance, some of them have pointed out how CBO said the Reid bill would lower premiums by 7 to 10 percent because of changes in the rules governing the insurance market.

As the Senate's only accountant, I take offense to these kinds of misrepresentations. Giving my Democratic colleagues the benefit of the doubt, I will assume they do not understand the differences between gross and net numbers.

I am not going to try to do a lot of numbers here. I did that once in committee and my staff watching back at the office—I got to ask the accountants at the SEC important questions at the time Enron was failing. You could see this little wedge of people seated behind the people testifying, and they were all asleep. I want to use this chart instead.

CBO did say the premiums would go down 7 to 10 percent due to insurance market changes. They also said premiums would go down another 7 to 10 percent because healthier people would sign up for insurance. What my colleagues forgot to mention or do not want to mention is that CBO also said that premiums would go up by 27 to 30 percent because the bill has so many mandates and requires most Americans to purchase more expensive coverage.

Yes, the Federal Government is going to tell you what you need for insurance, and then they are going to fine you if you do not get it. Maybe this chart helps to explain it.

We can see the net impact. Here is the 27 percent in increases because of

the mandates and the requirement to purchase more expensive coverage. This is the decrease that I mentioned. But you cannot just talk about this decrease and you cannot just talk about this decrease. You can talk about the net, and the net is a 13-percent increase in premiums.

I urge anyone who questions what I am saying to read the CBO letter. It is on the CBO Web site. Page 4 of the letter clearly states premiums will increase by 10 to 13 percent. That amounts to $2,100 for families purchasing coverage on their own. That does not meet the requirement that people in Wyoming think they are going to get. And the younger they are, the more surprised they are going to be because we get rid of the ratings, and young people will be paying considerably more. They are already paying into Medicare for seniors without getting any promise that will last until the time they become seniors, unless we pass something like the Judd Gregg amendment.

We have to protect that Medicare money to make sure it goes to Medicare and only Medicare if we are going to make sure Medicare stays solvent. We have to make that as a promise to the kids paying into the system now. They and their employers, and the amount the employers pay in, is the amount they could have in their own pocket if the employer did not have to pay it. But they are paying that so seniors can have the Medicare benefits, and we want them to have those benefits. We should not at this point take money from Medicare and build new entitlements and expect those same young people to pay an increased amount on while they pay an increase in their insurance premiums. Their insurance increase is going to be a lot more than 27 percent. In Wyoming, it was estimated to be around 300 percent. I think they will notice. I think they will be upset. If this bill passes, there will be a revolution in this country when people realize what has been thrust on them in this bill.

I yield the floor and keep the remainder of my time.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Madam President, I think everybody who is interested in the subject ought to read the CBO letter. Different people make different claims about the CBO letter, but I think it is only fair to read the entire letter, refer to the entire letter, not bits and pieces and parts of the CBO letter.

For example, it has been stated that CBO claims the average premiums—we are talking about the nongroup market. That is the individual market now. In fact, that is page 6 of their letter which said average premiums would be 27 percent to 30 percent higher because of greater coverage. That is the statement we just heard.

The CBO letter does say that. But I think it is also important to say that those people would be getting much higher quality insurance because of all the insurance market reforms we provide for in this legislation.

Even more important, CBO goes on to say on that same page in that same letter:

> The majority of these enrollees, about 57 percent, would receive subsidies via the new insurance exchanges, and those subsidies on average would cover two-thirds of the total premium.

It is true that some in the so-called nongroup market in the year 2016 would find their premiums go up without subsidies. I think that figure nets out to about 7 percent. But they are getting better insurance, much better insurance than they currently have because the insurance they buy in the exchange—we are talking about 2016—will be much better insurance than they now have.

According to everybody else, a fair reading of the CBO letter leads one to conclude that premiums will basically go down by a little bit—not a lot, a little bit—or be about the same. For example, I have heard on this floor the assertion, but no reference, no authority for this assertion—I heard this morning the assertion that for employees who work for larger companies, their premiums would go up. The fact is the CBO letter said just the opposite.

One can make the assertion premiums go up, but I think it is unfair to the American people to make rhetorical claims that are not backed up with authority. The CBO letter is probably the best authority we have for us to work with, and that letter says flatly that premiums for those persons—that is about five-sixths of Americans—would go down, not up, as has been asserted without the authority on the floor.

I am making the opposite assertion they will go down by about 3 percent. Not a lot but 3 percent. But my authority is the Congressional Budget Office. That is what they say.

Basically, 93 percent of premiums will either go down or be about the same. I mentioned a 3-percent reduction for the employees. Five-sixths of persons work for big companies and in the so-called small group market, CBO says—this is all the year 2016—premiums will be up 1 percent or down by 2 percentage points. It depends on who gets the credit. Some will, some will not.

Let's not forget small business gets credit under this legislation, too. I am not sure whether CBO calculated that in. A fair reading is the small group market, that is about 13 percent of Americans, it is, say, a net minus 1 because some go up 1 percent and some down by 2 percent.

Basically, if we compare apples to apples, that is what insurance will be in 2016—premiums will go down for those in the nongroup market, down by 14 or 20 percent. Because those with better benefits will find their premiums might go up by 10 to 13 percent and add in the tax credits which one has to do because that is the legislation, on a net basis, for two-thirds of those folks, their premiums will be lower by a large amount. By ''large,'' I mean by about 56 to 59 percent.

Who knows what is going to happen in 2016. CBO is giving their best shot based on this legislation. That is what their letter says. I have the letter right in front of me.

I might also say that CBO says—I don't know if it is in this letter or another letter—the bill is deficit neutral, and basically over 10 years—I think a 20-year period—the net effect is not much more government or less government, it is about the same as today. There are wild assertions: Oh, it is bigger government. CBO said government's involvement in people's lives will be basically no more or less than today, and that is partly because of a lot more choice people will have. They will have a lot more choice in the exchanges, a lot of choice under the exchanges. It is that choice which will encourage greater competition, and greater competition will encourage lower prices. At least that is the theory. Most of us tend to think competition lowers prices, and that is what the legislation does.

Unless the Senator from Wyoming wishes to speak, Senator KERRY, on our side, wishes to speak for at least 15 minutes.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KERRY. Madam President, I might pick up, if I may, on this issue of premiums. First, let me say it is astonishing to me how we are continuing here to have a debate about mythology and not reality. We keep trying to bring it back to reality. Our friends on the other side of the aisle, for better or worse, seem to be content to continue to try to scare America's seniors and to try to frighten people about this legislation overall.

I was listening to the debate about premiums, whether premiums are going to go up or premiums are going to go down. Let me share with people who are listening, particularly seniors, who I hope will not be scared by the false assertions that have been made; let me tell you about the experience in the Commonwealth of Massachusetts where we passed landmark health care reform 3 years ago.

Since implementing this plan in which we require—we require—every single citizen in the State to buy insurance, and employers are penalized if they do not provide insurance, the fact is that today in Massachusetts, the plan is working. The companies like it and the citizens like it because they have the coverage. In fact, coverage by companies, corporations, has gone up since we put it in place. There are more companies that now participate and find that it works for them than before. But most important, 432,000 people now have gained quality, affordable health care coverage where they didn't have it before.

We have the lowest uninsured numbers in the United States of America and we are proud of that. In Massachusetts, 97.3 percent of our citizens—more than we are attempting to cover under the legislation we want to pass here—97.3 percent of our citizens are covered and have health insurance. Equally important, the newly insured have enrolled in all types of private and public coverage. There are 18 percent who are in the State's Medicaid; 40 percent are in something called Commonwealth Care, which is administered by the Commonwealth, the new subsidized plan; 33 percent are in employer-based coverage; and 9 percent are in a nongroup purchase plan.

Let me say to the Senate, health reform has improved access in the Commonwealth of Massachusetts. There are fewer insured individuals who report cost as a barrier to being able to get care. In the last year, most Massachusetts residents—88 percent—had at least one visit to a doctor and 78 percent had a preventive care visit. A recent State survey found that 92 percent of individuals reported having a primary care provider in our State. As coverage has increased, the number of uninsured individuals going to hospitals for free care has declined. So we have reduced the number of people who sort of unfairly require everybody else to pay for their coverage when they go to a hospital and the hospital covers them, and it is paid for unevenly by the people who have coverage and by the corporations that have to make up the difference. That has gone down now. Now the free care has gone down because the people have a program, they have a plan, and they can go in and get the care that is afforded to them.

Here is what is important—and I say this to my friend who is managing for the Republicans right now—the average premiums in the individual market fell dramatically in Massachusetts—falling from $8,537 at the end of 2006 to $5,143 in mid-2009. In other words, premiums, which we have been arguing about, in the individual market, fell by 40 percent, while the rest of the Nation saw a 14-percent increase. Which would you rather have, a program where you spread the risk more fairly, where you lower the premiums and you provide quality care for people who don't have coverage today or continue the status quo, where you get thrown off your insurance by a company that just wants to take the profit and doesn't care about the fact that you got sick; that cuts you off after you have paid your premiums because they find a little catchphrase in the clauses of the contract and they tell you: Sorry, you are not covered when you are sick, or you can't even get covered because you have a preexisting condition when you walk in and you try to get the coverage.

I think the case is so clear it is almost unbelievable to me that we are here arguing about this at this point. But even more ridiculous is the following: The very same people who are coming to the floor right now and telling us not to slow the growth of Medicare, which is all that we are doing. We are not cutting any benefits. I hope every senior in America hears this. It is time to end these scare tactics. There is no cut in benefits. Every benefit currently under the law will continue to be given to the seniors of this country, and that is an obligation we have. But listen to what the people who are coming to tell you that there are cuts in your benefits used to say. I say used to say because it was when they had a Republican President and they were running the Senate.

The fact is, back in June 2009, because of a report on the long-term budget outlook, we know, point-blank, that if we don't cut, if we don't do something to reduce the rate of growth in Medicare, by 2080, the Federal Government is going to spend almost as much a share of the economy on just its two major health programs as it spent on all its programs in every branch of government in recent years. The Medicare provisions in this bill take the necessary steps to try to reform the delivery system through value-based purchasing initiatives, through bundled payments. A bundled payment is when you give a hospital or a delivery provider a sort of global budget, if you will. You give them a big amount of money and you say: This is what we are giving you, and you have to manage with that amount of money, instead of paying them for every single time somebody comes in to do something. When you give them that global budget, that so-called bundled budget, it encourages the executives to do what they haven't done today, which is find the ways to deliver the same quality of care but to deliver it more effectively and more efficiently.

We provide the creation of an innovation center to test new payments, to have comparative effectiveness research. Doesn't that make sense? We want to know if what they are doing in Wyoming or what they are doing in Colorado or some other part of the country makes as much sense as what they are doing in Kentucky or Massachusetts or West Virginia somewhere. By looking at the comparative effectiveness, we will all learn and become more effective and more efficient at delivering services. Thanks to the distinguished Senator from West Virginia, we create an independent Medicare advisory board, which will have a profound impact on forcing the Congress to make decisions we have avoided for far too long.

Our colleagues who are here today saying: Don't do this. Don't be smart about Medicare. That is effectively what they are saying because that is what we are doing. We are trying to be smart about Medicare. We are not cutting any benefits. But they are coming here and telling you we are cutting benefits, even though in June of 1995, June 28, Senator GRASSLEY from Iowa came to the floor and said:

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

On June 29, 1995 Senator JOHN KYL said:

> We do heed the warning of the Medicare board of trustees and limit growth to more sustainable levels to prevent Medicare from going bankrupt in 2002.

Medicare, we think, is not going to go bankrupt until 2017. Thanks to what is in this bill, we actually extend the life of Medicare another 4, definitely, and hopefully 5 years. But here is what Senator KYL said:

> Preventing Medicare from going bankrupt is what is necessary to make sure seniors do not lose their benefits altogether as a result of bankruptcy in 7 years.

On June 29, 1995, Senator HATCH said:

> It is important to start the structural reforms which are necessary to make Medicare solvent in the long term.

That is exactly what we are doing. That is precisely what we are doing, and we should have the support of Senator KYL and Senator GRASSLEY and Senator HATCH.

On October 17, 1995, Senator KYL said:

> We also know that it is necessary to prevent the Medicare program from going broke. The Republican budget will slow the growth in Medicare because the Medicare trustees have warned us that without doing so the system will go broke. I think that it is totally irresponsible for any organization in America to be scaring America's senior citizens.

I am quoting Senator JOHN KYL: ''. . . irresponsible for any organization . . . to be scaring America's seniors.'' Yet here is the Republican Party scaring America's seniors.

I wish to talk about what this legislation does and doesn't do because every claim that is being made is simply without foundation. This amendment is basically an amendment designed to try to gut this bill and what it does is condition any spending increases or tax reductions in the bill on certification that all costs in the bill are offset, without counting changes in Medicare or Social Security. That is a gimmick. It is a game. It is calculated to prevent us from taking the positive changes we make and using those positive changes in an effective way to do even more that is positive.

I wish to be very specific about more that is positive, but I want to, first, go through each of the claims made by the other side. First of all, they claim the Medicare payroll taxes are used in this bill to pay for non-Medicare benefits. They say this bill raises the Medicare payroll tax so we pay for non-Medicare benefits. Well, it is not true. It is true the payroll tax goes up for an individual with an income over $200,000 and for a married couple with an income over $250,000. But let's set the record straight. By law—and nothing in this bill changes that law—all Medicare payroll taxes are used to improve the solvency of the Medicare Program. This bill does not change that practice, notwithstanding anything they try to say, and it certainly doesn't divert

Medicare payroll taxes to another program.

Even the CMS actuary has certified that because of the Medicare provisions contained in this bill, the solvency of the Medicare Part A hospital insurance trust fund will be improved by 5 years. So what they are saying with respect to that is simply not true.

They also claim Medicare cuts are used to pay for coverage expansion. This statement actually ignores the benefits seniors receive from this bill.

I think it also is important to remind people how the Medicare financing system works. I just talked about the Medicare solvency in the Part A Program. The Part A Program is paid through payroll tax. The Part B Program and the prescription drug program is paid through a combination of general revenue contributions and enrollee premiums. About 25 percent of the total program cost is paid through the premium, and 75 percent is paid by the general revenues. Part D financing works exactly the same way.

This bill reduces Medicare spending by a total of $463 billion. It doesn't reduce the benefits, but it reduces the spending over the next 10 years. Do you know what that does? That lowers the out-of-pocket premiums beneficiaries pay for Medicare physician services and prescription drug coverages. In effect—and this has already been certified by CBO—we lower the premiums for seniors. That is the benefit.

The opponents claim the Medicare cuts to providers are going to result in decreased access. Well, it is interesting that the very same people who brought us the so-called death panels, which never existed, are at it again with respect to access. They want to scare you. They want to say you are not going to get access to a doctor or access to your medical care, and they claim Medicare benefits could be harmed by the bill. Yet, even as they say that, AARP, the people who represent 40 million retired Americans, says: No, no, no, that is not true. Our people are protected. The American Medical Association says: No, no, no, that is not true. The folks we care about are protected.

This bill fully protects guaranteed Medicare benefits for seniors. It will keep Medicare from going broke in 7 years, it extends the life of the Medicare trust fund, it reduces prescription drug costs for seniors, it ensures seniors can keep their own doctors next year by blocking a 21-percent pay cut for physicians, it creates new prevention and wellness benefits in Medicare, and it keeps seniors in their own homes and not in nursing homes.

The ACTING PRESIDENT pro tempore. The time of the Senator has expired.

Mr. BAUCUS. Mr. President, I yield an additional 5 minutes to the Senator from Massachusetts.

The ACTING PRESIDENT pro tempore. The Senator may proceed.

Mr. KERRY. I thank the distinguished leader and the Chair.

So the opponents of health care reform are simply not telling you that the program is about to be insolvent because private insurance companies and some of the providers are, in fact, using the money basically to get rich off the Medicare dollar.

We ought to be clear about the impact of these policies. Even with the Medicare changes we have made—I hope Medicare beneficiaries hear this—even with the Medicare changes in the bill, overall provider payments are still going to go up. They are not cut. They are going up. We are simply slowing the rate of growth, and that is something everybody on the other side has said they want to do.

Wall Street analysts also have suggested that many providers, including hospitals, are going to be ''net winners.'' That is a quote, ''net winners.'' Under our bill, they estimate hospital profitability will increase with reform because more and more hospital patients will have private insurance that they do not have today and the hospitals today are out of pocket because they take care of these people but they do not have the insurance. Just as in Massachusetts, where the premiums went down and where the expenses for free care went down, that is precisely what the impact will be here.

We have a choice. We can do nothing, which is basically what our colleagues have proposed. The status quo means Medicare is going to be broke in approximately 7 years. It means seniors are going to pay higher and higher premiums and cost sharing due to wasteful overpayments to providers. It means that each year billions of Medicare dollars are going to continue to be wasted, lining the pockets of the private insurance companies that kick people off indiscriminately or tell them they don't have the coverage when they finally get sick and need the coverage. The status quo means seniors are going to continue to pay for their prescription drugs.

The fact is, this is the time for responsible action. This bill strengthens the Medicare Program, it reduces premium costs for seniors, it restores Medicare's financial integrity, and it fortifies Medicare and protects Medicare benefits for America's seniors.

Let me point to another thing they keep saying. They keep saying this bill cuts billions of dollars from the Medicare Advantage Program, hurting the 11 million seniors who are enrolled in those programs today. I know that is exactly what they have said—this bill cuts Medicare Advantage and hurts those millions of seniors. Wrong, not true, scare tactic, same old procedure, trying to distort and provide fear. Nothing could be further from the truth. This bill cuts down on overpayments, not benefits. What taxpayer in America should knowingly be paying an additional amount for a service, more than the service is worth and more than we pay in the regular program?

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

Mr. KERRY. I want to finish the thought. If we can yield on your time at the end, I will be happy to do that, but I want to make the points.

It is the overpayments to insurers that actually threaten Medicare's future. That is what increases the costs for seniors.

In 2009, MedPAC, the independent commission that advises us on issues affecting Medicare, estimates that Medicare is going to pay approximately $12 billion more for beneficiaries enrolled in private Medicare Advantage plans than if they were in the traditional Medicare. These are overpayments, according to MedPAC and according to folks in the medical profession. They exist because private insurers, under Medicare Advantage, are overpaid by about 14 percent, on average.

I might add, coincidentally, in 2008, when the Senator from Arizona was the nominee for President, one of his top aides, Mr. Douglas Holtz-Eakin, said—I think it was in an article in USA TODAY—that Medicare Advantage plans should ''compete on a level playing field'' with traditional Medicare. The changes in this bill will help to reduce these overpayments, and they bring us closer to that level playing field that was suggested last year.

My friends on the other side of the aisle also say that reducing the government subsidies to private medical plans is going to increase the costs for seniors. Again, this statement is fiction. The overpayments private insurance companies receive under the current law to deliver Medicare benefits have increased the costs for seniors today. They, in fact, result in a $90 increase in premiums to every married couple enrolled in Medicare.

As we go forward, I hope it is the truth and facts that will prevail here, not the fiction we keep hearing to scare seniors.

Americans ought to take note that the Minority do not come to the floor of the Senate and show us how we could fix Medicare's problems more effectively. The minority does not support changes that serve seniors better. Instead, they just embrace the status quo. Everyone in America knows the status quo is unacceptable. We cannot afford it. Medicare will go bankrupt within the next 10 years. I ask my colleagues, then where are we going to be?

This is the time for responsible action, and every step we have offered offers that kind of responsible action without reducing care. Opponents of health reform won't rest. They are using myths and misinformation to distort the truth and wrongly suggest that Medicare will be harmed. After a lifetime of hard work, don't seniors deserve better?

The Patient Protection and Affordable Care Act clearly strengthens the Medicare program. The bill reduces premium costs for seniors, improves

Medicare's financial integrity and delivers immediate benefits for seniors like lower prescription drug costs and free preventive services. In short, health care reform will fortify Medicare and protect Medicare benefits for America's seniors.I would like to take the next few minutes to separate the facts from the fiction.

My friends on the other side of the aisle say that health reform will cut Medicare benefits for seniors. And once again, this statement is false. Health reform will increase the number of Medicare benefits that seniors are entitled to under law. Nothing in this bill will take away or reduce guaranteed Medicare benefits. In fact, the legislation increases coverage of preventive services at no additional costs to seniors. That means, when seniors visit a doctor for a colonoscopy, mammography, or other preventive screen, they won't pay the co-pay required under current law. Encouraging more preventive care is one of the best ways we can save lives and lower health care costs. That's why, under this bill, seniors will receive even better preventive benefits than they receive today.

My friends on the other side of the aisle say that under health reform, government bureaucrats will dictate personal health care decisions. This statement is completely false. Health care decisions about providers and treatments are some of the most personal decisions many people make. Under current law, doctors and patients decide which treatments Medicare patients need. The same is true under this bill. Health reform will keep these decisions between health care providers and patients. And with improved payment policies, this bill also ensures Medicare providers get the resources they need to continue providing quality care to their patients.

My colleagues on the other side of the aisle say that reducing fraud, waste and abuse in Medicare will not save a significant amount of money. To the contrary, waste, fraud and abuse cost the health care system billions of dollars every year. Improving Medicare's financial integrity is one of the first steps we can take to save the program. According to independent analysis from the Congressional Budget Office, under this bill, enhanced oversight, like requiring background checks and screening for providers, will save Medicare dollars. Targeting waste, fraud and abuse in Medicare will protect American taxpayers and help extend the life of the program.

My friends on the other side of the aisle claim that health care reform will not lower costs for seniors but drive costs higher. The truth is that seniors will see immediate savings in prescription drug costs under health care reform. This legislation will save seniors money in the Medicare prescription drug coverage program by providing more coverage and lowering the costs of brand-name prescription drugs. In 2010, seniors will receive an additional $500 of coverage before they have to begin paying out of their own pocket in the coverage gap or ''doughnut hole'' in the Medicare Prescription Drug Benefit. Also beginning in 2010, the price of brand-name drugs and biologics will be cut in half for the seniors who have to pay for prescriptions out of their own pocket when they hit the ''doughnut hole'' between initial and catastrophic coverage.

Those on the other side of the aisle say that we are not doing enough to protect home health care. The fact is that this bill includes provisions I introduced to make home and community-based services more widely available in Medicaid. Despite advancements in home and community-based services, seniors have few affordable and accessible options in choosing a health care setting today. Seniors deserve more options, rather than just nursing homes. For seniors eligible for both Medicare and Medicaid and who prefer home or community-based services, this bill provides valuable support.

We have heard repeatedly from my friends on the other side of the aisle that leading advocacy groups do not support the Senate health care bill. Nothing could be further from the truth. The country's leading advocacy groups for seniors rights are helping stop the scare tactics and clear up the facts. Voices like AARP and the American Medical Association support the responsible Medicare reform in this bill.

On November 18th, AARP said:

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

On November 20th, the American Medical Association said:

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

On November 16th, the Federation of American Hospitals said

Hospitals always will stand by senior citizens.

And on November 16th, the Catholic Health Association of the United States said:

The possibility that hospitals might pull out of Medicare [is] very, very unfounded. Catholic hospitals would never give up on Medicare patients.

The minority today is arguing the exact opposite of what they have said previously. In the late 1990s, Republicans and Democrats joined together to fight for America's seniors, advocating Congress take the advice of experts who said the solvency of Medicare was in trouble. Today, some are using scare tactics, falsely claiming that the Patient Protection and Affordable Care Act will impose ''cuts to Medicare'' that hurt seniors. In truth, this bill protects the guaranteed Medicare benefits our seniors deserve. I urge my colleagues to stop spreading the misinformation and false claims about this bill that are intended only to scare seniors. Instead, I urge you to work with us on this legislation which delivers health care to an additional 31 million Americans and strengthens and preserves Medicare for the 45 million beneficiaries who rely on the program.

The PRESIDING OFFICER (Mr. ROCKFELLER). The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I ask unanimous consent that following the comments of the Senator from Massachusetts, an article be printed in the RECORD called ''The Coming Deficit Disaster'' by Douglas Holtz-Eakin, the same Congressional Budget Office Director to whom he was referring. That goes into a number of these points I probably will do later, but I want it at this moment because I want to relinquish such time as the Senator from Oklahoma might want.

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

THE COMING DEFICIT DISASTER

The president says he understands the urgency of our fiscal crisis, but his policies are the equivalent of steering the economy toward an iceberg. By Douglas Holtz-Eakin (Mr. Holtz-Eakin is former director of the Congressional Budget Office and a fellow at the Manhattan Institute. This is adapted from testimony he gave before the Senate Committee on the Budget on Nov. 10.)

President Barack Obama took office promising to lead from the center and solve big problems. He has exerted enormous political energy attempting to reform the nation's health-care system. But the biggest economic problem facing the nation is not health care. It's the deficit.

Recently, the White House signaled that it will get serious about reducing the deficit next year—after it locks into place massive new health-care entitlements. This is a recipe for disaster, as it will create a new appetite for increased spending and yet another powerful interest group to oppose deficit-reduction measures.

Our fiscal situation has deteriorated rapidly in just the past few years. The federal government ran a 2009 deficit of $1.4 trillion—the highest since World War II—as spending reached nearly 25% of GDP and total revenues fell below 15% of GDP. Shortfalls like these have not been seen in more than 50 years. Going forward, there is no relief in sight, as spending far outpaces revenues and the federal budget is projected to be in enormous deficit every year. Our national debt is projected to stand at $17.1 trillion 10 years from now, or over $50,000 per American. By 2019, according to the Congressional Budget Office's (CBO) analysis of the president's budget, the budget deficit will still be roughly $1 trillion, even though the economic situation will have improved and revenues will be above historical norms.

The planned deficits will have destructive consequences for both fairness and economic growth. They will force upon our children and grandchildren the bill for our overconsumption. Federal deficits will crowd out domestic investment in physical capital, human capital, and technologies that increase potential GDP and the standard of living. Financing deficits could crowd out exports and harm our international competitiveness, as we can already see happening

with the large borrowing we are doing from competitors like China.

At what point, some financial analysts ask, do rating agencies downgrade the United States? When do lenders price additional risk to federal borrowing, leading to a damaging spike in interest rates? How quickly will international investors flee the dollar for a new reserve currency? And how will the resulting higher interest rates, diminished dollar, higher inflation, and economic distress manifest itself? Given the president's recent reception in China—friendly but fruitless—these answers may come sooner than any of us would like.

Mr. Obama and his advisers say they understand these concerns, but the administration's policy choices are the equivalent of steering the economy toward an iceberg. Perhaps the most vivid example of sending the wrong message to international capital markets are the health-care reform bills—one that passed the House earlier this month and another under consideration in the Senate. Whatever their good intentions, they have too many flaws to be defensible.

First and foremost, neither bends the health-cost curve downward. The CBO found that the House bill fails to reduce the pace of health-care spending growth. An audit of the bill by Richard Foster, chief actuary for the Centers for Medicare and Medicaid Services, found that the pace of national health-care spending will increase by 2.1% over 10 years, or by about $750 billion. Senate Majority Leader Harry Reid's bill grows just as fast as the House version. In this way, the bills betray the basic promise of health-care reform: providing quality care at lower cost.

Second, each bill sets up a new entitlement program that grows at 8% annually as far as the eye can see—faster than the economy will grow, faster than tax revenues will grow, and just as fast as the already-broken Medicare and Medicaid programs. They also create a second new entitlement program, a federally run, long-term-care insurance plan.

Finally, the bills are fiscally dishonest, using every budget gimmick and trick in the book: Leave out inconvenient spending, back-load spending to disguise the true scale, front-load tax revenues, let inflation push up tax revenues, promise spending cuts to doctors and hospitals that have no record of materializing, and so on. If there really are savings to be found in Medicare, those savings should be directed toward deficit reduction and preserving Medicare, not to financing huge new entitlement programs. Getting long-term budgets under control is hard enough today. The job will be nearly impossible with a slew of new entitlements in place. In short, any combination of what is moving through Congress is economically dangerous and invites the rapid acceleration of a debt crisis.

It is a dramatic statement to financial markets that the federal government does not understand that it must get its fiscal house in order. The time to worry about the deficit is not next year, but now. There is no time to waste.

Again, Mr. Holtz-Eakin is former director of the Congressional Budget Office and a fellow at the Manhattan Institute. This is adapted from testimony he gave before the Senate Committee on the Budget on Nov. 10.

Mr. COBURN. Mr. President, the question I was going to ask the distinguished Senator from Massachusetts is, how many Medicare Advantage patients has he ever cared for? How many Medicare Advantage—how many Medicare patients has he ever cared for? How many times has he been in the trough, experiencing the heavy hand of government as we try to care for people on Medicare? The answer to that question is zero because he is not a physician. He relies on the American Medical Association—the American Medical Association that today represents less than 10 percent of the active practicing doctors in this country. He relies on AARP, which has 40 million in membership but is the fifth largest revenue receiver from supplemental policies. That is whom he relies on. The fact is, he does not have the experience of being in the trough, caring for patients.

Let me tell you what is going to happen to Medicare Advantage patients.

Mr. KERRY. Will the Senator yield——

Mr. COBURN. The Senator would not yield to me. I have no intention to yield to him.

Mr. KERRY. I was ready to yield on your time.

Mr. COBURN. The Senator would not yield. I will continue my talk.

For Medicare Advantage patients—there is no question, I have agreed with the chairman of the Finance Committee—the competitive bidding needs to happen. But there is one little thing that happened on the way to the bank. It is that there is going to be a decrease in benefits—not only a decrease in what we pay for, but there is going to be a decrease in benefits. Where will that impact be most importantly felt? Not in the urban areas. It is not going to be felt in the urban areas. It is going to be felt in rural areas throughout this country. That is where it is going to be felt. It is going to be felt out there where there is a marginal rural hospital that is using the other benefits to help maintain the flow to that hospital.

So there is no question that, if you are one of the 11 million—with the exception of those who got deals cut in this bill—that, for sure, the 90,000 Oklahomans are going to feel an impact from this cut.

Nobody says Medicare Advantage is perfect. It is not. It is far from it. But there is another aspect of Medicare Advantage that really helps those on the lower rung of the economic ladder. It is that with Medicare Advantage, they did not have to buy a supplemental policy because all the things they need are covered.

Ninety-four percent of Americans on Medicare who are not on Medicare Advantage purchase a supplemental policy. Why do they do that? Why do they spend $300 or $400 a month to buy a supplemental policy? Because basic Medicare that we have proudly said will not be cut does not cover the basic needs of a senior and their health care. Consequently, they pay into Medicare Part A, HI trust fund their whole life, they buy Medicare Part B, and then they buy a supplemental policy. It just so happens that one of the largest sellers of those policies happens to be somebody who is endorsing this bill. If that is not a conflict of interest, I don't know what is.

I heard the Senator talk about Massachusetts. I refer to an article from the Chicago Tribune—they have broadened care. I am proud of them for doing that. But at what cost? At a 10-percent increase in cost of premiums for the people in the middle.

When we go back to what the President said about what his goals are, there is no question that this bill does not keep those promises.

I now ask unanimous consent to turn to another area which we have discussed and ask unanimous consent to have printed in the RECORD an article from the North County Times/The Californian, dated December 5, 2009, at 9:35 p.m.

Mr. KERRY. Reserving the right——

The PRESIDING OFFICER. It is so ordered—the Senator from Massachusetts?

Mr. KERRY. I reserve the right to object. I want to find out if we can have a moment to have a discussion, I ask my colleague.

Mr. COBURN. I will offer you the same courtesy you offered me. When I finish my remarks, on your time, you are more than welcome to refute what I said.

I ask unanimous-consent that be printed in the RECORD.

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

The Senator's unanimous-consent request is granted as it was before.

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

[From the North County Times, Dec. 5, 2009]

STATE ENDS SUBSIDY FOR MAMMOGRAMS TO LOW-INCOME WOMEN UNDER 50

(By Bradley J. Fikes)

The eligibility age for state-subsidized breast cancer screening has been raised from 40 to 50 by the California Health and Human Services Agency, which will also temporarily stop enrollment in the breast cancer screening program.

Advocates for low-income women, whose health care the department helps pay for, say the cuts put a two-tier system in place that is based on money rather than medical standards.

The cuts will greatly harm the clinic's mammogram program, said Natasha Riley, manager of Vista Community Clinic's Breast Health Outreach and Education Program.

The clinic and others like it in San Diego County provide reduced-cost care, mostly to low-income people, with money from the state and some private donations.

''More than 50 percent of the women we give breast exams and mammograms to are in their 40s,'' Riley said. ''The majority of our current breast cancer survivors are women in their 40s.''

The state's decision, announced Dec. 1 and effective Jan. 1, follows a controversial federal recommendation last month that mammograms before the age of 50 are generally not needed.

However, the public health department also linked the change to California's budget woes.

The federal recommendation, made Nov. 16 by the U.S. Preventive Services Task Force, has encountered strong opposition.

The task force later retreated a bit, adjusting its recommendation to state that mammograms for women ages 40 to 49 should be

considered by their doctors on an individual basis.

Moreover, private health care systems such as Scripps Health have rejected the federal task force's recommendation, choosing instead to keep the existing standard, which calls for a mammogram at age 40, with annual mammograms thereafter.

That means doctors will be using two medical practice guidelines, distinguished not by knowledge but by the pocketbook, said Dr. Jack Klausen, a gynecologist and obstetrician who practices at Vista Community Clinic.

''If we are in a situation where we don't screen, but the private-practice doctor can screen, then we are actually not practicing to the standard of care,'' Klausen said.

In its announcement, the state said the cuts were needed because of a projected budget shortfall for the California Department of Public Health, and from declining revenue from tobacco taxes.

However, it did not say how much money it expected to save.

Calls to the department were not returned Friday.

The policy puts lives at risk, said Barbara Mannino, CEO of Vista Community Clinic.

''I bet you everybody knows a woman who was diagnosed in her 40s, and her life was saved by a mammogram, or lost because it was too late,'' Mannino said, just before leaving for her own mammogram.

And she said that little money would be saved, because all the equipment and staff to provide mammograms is already in place.

There is a difference of opinion in the medical community about when mammograms, an X-ray of the breast, should be used.

Mammograms sometimes give false alarms, with the incidence of false positives especially high for women in their 40s.

Estimates are that 10 percent to 15 percent of mammograms give false positives, experts say.

False negatives, in which the cancer is present but the mammogram seems normal, occurs 20 percent of the time, according to the National Cancer Institute.

However, false negatives become less frequent with age.

But the benefits in finding cancers when they are more easily treatable outweigh the drawbacks, Mannino and Klausen said.

And Scripps' breast cancer task force said that because 28 percent of women newly diagnosed with breast cancer are younger than 50, the number of lives saved outweighs the additional cost.

Klausen said the federal panel was trying to ''create a best-practices (standard) from a monetary point of view,'' to provide the most health care for all, out of a limited budget.

Women who get false positives on mammograms not only undergo stress, but they must go through other tests, only to find out there's nothing wrong.

That adds costs to the system without providing any better health care, according to the federal panel's reasoning.

However, Klausen said the state has taken that reasoning too far, putting too much emphasis on saving money.

''What makes me really worried is that the California Department of Public Health wants to save money by taking away a cancer-detection program,'' Klausen said. ''That discriminates against a gender, and also discriminates against an income level. And it also discriminates against how community clinics can practice medicine.''

Mr. COBURN. In this bill, what we are debating are three terrible things for care but great things for cost: the U.S. Preventive Task Force on Prevention Services, the Medicare Advisory Commission, and the references to the Cost Comparative Effectiveness Panel.

When the U.S. Preventive Services Task Force came out with their recommendation, as far as costs—I am talking about breast cancer screening for 40- to 49-year-olds—as far as costs, they were absolutely right, as far as cost-effectiveness. But as far as clinical effectiveness, they were absolutely wrong. What did we do? We accepted a Vitter amendment to hold off, so that recommendation, that mandate from that panel will not apply to women in this country under these programs—except the women in California on Medi-Cal because, you see, this week California embraced the U.S. Preventive Services Task Force. So if you are a Medicaid patient—which we are going to put 15 million more people into—you cannot have a mammogram in California if you are under 50. You cannot have it because, from a cost standpoint, they are right. From a clinical standpoint, they are wrong.

What we have done is, every time one of these three organizations creates a ruling, that the American people rise up and say: That is wrong, we are going to come in here and correct it? But throughout this bill, strung throughout are multiple references to what these three panels are going to ration—I did not miss that word—ration the care to American people in this country.

If you are a senior, you have two real reasons to be worried. One is, we are cutting Medicare. And if we are not, then vote for the Gregg amendment and you will make sure we don't. It is an insurance policy. But more important, within that, we are going to see the care to seniors rationed based not on what is in their own best interests or their health's best interests but what is in the cost's best interests. There is no question about it. We are going to do that.

It would be different if we created a comparative effectiveness panel, a clinical comparative panel. But they are already out there. We knew that.

When I study to take my recertification exams, I have to know what the clinical comparative effectiveness guidelines are or I will not pass as a practicing physician. But we didn't do that. We said: Cost is most important. So how are we going to cut? We are going to say where something is cost-effective though not clinically effective, we are going to cut that care.

So if you are a senior, especially if you are on Medicare Advantage, you don't have to just worry about the fact that we are going to decrease the revenue stream that will supply those benefits that cause you not to have to buy a supplemental policy, and we are going to decrease some of the things that are available to you as a Medicare Advantage patient, but you also have to worry about the next ruling that is going to come from the U.S. Preventative Health Services Task Force. You have to worry about what is going to come from the Medicare Payment Advisory Commission because it is going to be looking at costs too.

Then you have to worry about what is going to come from the cost comparative effectiveness panel. I could spend up to 8 hours talking about tragedies from England and Canada on care denied based on things Americans have today that that very panel is going to deny to Americans in the future because they are not cost-effective. That is one of the reasons our result in terms of cancer treatments is one-third better than anywhere else in the world. It is because we don't have mother nanny bureaucracy saying what you can and cannot have.

It would be totally different if we created incentives for lowering the cost, but we don't. We create mandates. We drive down the cost of health care in specific areas through these three separate panels.

There is one thing that is even worse than the two things I just talked about for Medicare patients. Here is what it is. When you have these three panels, you have just taken away the loyalty of your physician to you. You have just decided, with these three panels, that the physicians have to keep their eyes on the government. They have to do what the government says is in your best health interest rather than what that provider knows is in your best interest. Remember, the Medicare Payment Advisory Commission, the cost comparative effectiveness panel, and the Preventative Services Task Force doesn't know your family history, doesn't know your clinical history, has never done an exam on you, do not know the idiosyncrasies of your health care. But we are going to apply that all to you; we are going to depersonalize health care.

I readily admit, for 80 percent of the people, it is going to be just fine. They will not see any untoward result. But I will predict, as a practicing physician for over 25 years, for that remaining 20 percent it is going to be a disaster as far as their personal health is concerned. It will destroy the patient-doctor relationship. It will give us worse outcomes, and it will not save us any money because the consequences of those decisions will create a complication which will require more dollars expended.

When we think the government can practice medicine—and that is what this bill does; this bill sets up the government to practice medicine—we might as well hang it up and just be ready because 20 percent are going to get substandard care compared to what a Medicare patient receives today. We are going to get sicker. The life expectancy of people under this health care bill will decline. The quality of care will decline. The innovation of new advancements in health care will decline because we have chosen the government to decide what everybody will get. It is a disaster as far as the individual patient is concerned.

That is not the motivation of my colleagues on the other side. I know that. I am not accusing them of that. But what they don't see, sitting in Washington, is what I see in a clinic office practice in medicine. Medicine is intensely personal. It ought to be about your choice, about what is best for you and your family and your children, not what the government says makes the best economic sense to the budget picture in Washington any particular year. When we lose that quality in American medicine, we are going to lose the best of what we have in the name of fixing what is wrong.

I agree with my colleagues the insurance industry has a lot of stink to it. But there are a lot of ways to fix it other than the way we have done. I agree with my colleagues that my profession is not pure at every turn of the corner. I agree with my colleagues we can do better. But when we write a bill that is absent any absolute clinical judgment left to the practice of medicine by those who know the patients best, who have 100 percent of that patient's best interests at heart, we are going to hurt the quality of care. We are going to hurt it significantly. Your motivations are good. The answers are wrong on a clinical basis.

Now to the Gregg amendment. The Gregg amendment does what you all say you want to do. I remind my colleagues the Medicare trustees are highly suspicious of the Medicare cuts in this bill. What they say is, they highly doubt it will ever happen because it has never happened before because there is not the political will to decrease the dollars in Medicare. More importantly, the dollars are going to come out of care instead of out of fraud. There is only $2 billion, say, out of at least $100 billion a year, in fraud. Only 2 percent of it per year is coming out. That is the problem. We could have had a Medicare bill and we could have cut $60 or $70 billion of fraud together out of this bill. We can come together on that. We could have cut $720 billion out of Medicare just based on fraud alone without ever touching Medicare Advantage, without ever giving sweetheart deals to the people in Florida because their Senator wanted it, without ever touching FMAP adjustments in other States.

We could have done that, but we chose not to. We chose what we know up here rather than what we know in the hinterland, those of us who are practicing medicine. What do we know? We know there are some rip-offs in home health care. We know there are significant rip-offs in durable medical equipment. We know there are some rip-offs in hospice. We know there are drug company rip-offs. We could agree to some of those. We actually even know in large hospitals that there are some problems there as well. But there are very few problems in our rural hospitals because they are struggling just to keep the doors open. We could have done that, but we chose not to. So we have this divide, and we are going to fix it one way. The biggest pot of honey in Medicare is fraud. Everybody knows that. But we are not going to fix it.

If, in fact, what my colleagues claim is true, that these are Medicare cuts that nobody will ever feel any consequence from, in spite of my own years of practice and knowing the difference, that that isn't true, but let's give you that, why would we not put it all back in Medicare so we don't steal from our children and our grandchildren? Why would we not do that? We have chosen not to do that. We have chosen to mix it. And it is honorable to try to create a system to get more people insured. Yet we will still have 24 million people not insured. Out of this bill, we will still have 24 million people not insured, when it is all said and done, if everything goes as planned.

Yesterday I introduced into the RECORD the analysis by the State insurance commission in the State of Oklahoma. Kim Holland is of your party, the majority party. But she sees what is getting ready to happen with this bill. What does she say? What she says is, insurance premiums are going to significantly rise in Oklahoma. More people will be uninsured than there are today. The State Medicaid fund is going to be tremendously stressed with at least $67 million a year having to go into that, again, based on the mandates in this bill that we don't have money to do; that, in fact, it is not the way to solve what Oklahoma is facing in terms of health care.

I didn't call her and say: Give me something bad to say about this bill. She volunteered this information out of her legitimate concern for the consequences, of what is going to happen with this bill. Why would she do that? Because she knows one heck-of-a-lot more about insurance than I do and anybody else in this body. She knows it in our State. And the other insurance commissioners around here, some through their association, have endorsed this bill. Most, when they look at their State, especially the poorer States, especially West Virginia, it is going to hurt.

How are we going to cover that? We are going to shift 15 million people to Medicaid. What do we know about Medicaid? I have delivered thousands of babies and over half of them have been Medicaid. I have cared for thousands of Medicaid children, thousands of Medicaid adults and thousands of Medicaid patients. What do we know? Medicaid is a substandard program. Compared to everybody else, it is substandard, except when compared to the Indian Health Service, and that is a disaster. So our answer is to put a mandate on the States that they cannot afford and shove another 15 million people into a system that has poorer outcomes, higher complication rates, higher infant mortality rates, later presentation, and a system that has 11 million people eligible for it today who are not signed up.

We have the system out there, but they are not signed up. So they are not getting any preventative care. They are not interacting with a primary care physician.

And that is our answer? Move 15 million more Americans into Medicaid. By the way, keep a discriminatory stamp on their forehead, rather than give them an insurance program; put a stamp on their forehead that says 40 percent of the doctors can't see you, 65 percent of the specialists will not see you because your reimbursement rate is so low they can't afford to have you walk into their office and cover the cost of seeing you. That is what we are going to do.

That is not reform to health care. That is banishing people to a substandard system as compared to what the rest of the system is and then feeling good about it. That is not reform. That is discrimination because here is what really happens to a Medicaid mom and her children.

If she has a sick kid, she can't get in. She has this 6-year-old with a fever, not eating, dehydrated, and she can't get in to see a primary care physician, which could keep that child out of the hospital. So what happens? She keeps trying to get in. What does she do? She accesses the emergency room, the most expensive place. She accesses it late—not early, late.

So we have a sicker child, with higher costs, because we have a system that will not reimburse its costs. And you all have actually talked about the cost shift on that, from Medicare and Medicaid, to the private sector. We would be much better off paying the same rates in Medicaid so we do not get that cost shift, so we do not discriminate against people on Medicaid for access to care. But we have chosen not to do that because it fits with the numbers. It fits with the Washington, government-centered management of health care.

I will tell you as a physician, we would be better off—single-payer rationing and all—than what you are doing to so many of these patients in this bill. We would be better off with the government just running it all, rationing it, and saying: Tough, you get to 75 years of age, you can't get your hip fixed; you get cancer, we are not going to give you the latest drugs. We would be better off because now we are going to get the worst of both worlds. We are going to get the rationing through these three panels I talked about. They are going to tell doctors what they can and cannot do. They are going to practice medicine—the very people who have never touched, never had an encounter, never visited with that patient and do not know anything about them—they are going to make a decision.

Mr. President, I would inquire, I think I have 5 minutes.

The PRESIDING OFFICER. The Senator is correct.

Mr. COBURN. What is the request of my ranking member?

Mr. ENZI. Senator SESSIONS?

Mr. SESSIONS. Mr. President, I will just respond by saying to Senator COBURN, I think he should use the remainder of the time, and then I will be able to work with the Democrats to get time.

Mr. COBURN. I think I will finish up in seconds.

Mr. SESSIONS. I say to the Senator, take the remainder of the time, if you would like it. I will get my opportunity in a few minutes.

Mr. COBURN. Every person in this country should be able to have access. I agree. Nobody should lose their home. Nobody should have to file for bankruptcy because of health care. I agree. That premise we agree on. How we get there is in two totally different ways.

The No. 1 impediment to access is cost. Costs are not going to go down. We know that by all the studies. The health care costs are not going to go down. They are not going to go down per individual and they are not going to go down in total. So we will not have fixed the big problem with health care, which is cost.

We will have worked on access through a government program, but we will not have fixed the real problems. What are the real problems? Fraud is at least 6 percent of the cost of health care. Tort extortion by the trial bar is at least 6 percent of the cost of health care when you count defensive medicine. There is 12 percent where you could lower it tomorrow—12 percent where you could lower the cost of health care tomorrow if, in fact, we would fix the real problems.

No. 3, transparency with insurance companies and transparency with doctors so you know what the cost is, you know what the outcomes are, you know what their track record is, so you can truly make a decision about your care. There is no incentive for that, the incentivization for prevention and management of chronic disease.

I have said this on the floor before, but it bears repeating: The reason we have a primary care doctor shortage in this country today is because of Medicare. The Centers for Medicare & Medicaid Services sets the rates of reimbursement for primary care encounters in Medicare, and everybody else follows it. So you have a disruption, a differential of 300 percent from a family practice doctor and an obstetrician like me to a super-subspecialist. And what do you think the doctors in medical schools are doing? Last year, only 1 in 50 went into primary care. Only 1 in 50 went into primary care.

So let's say we get everybody covered. Who are they going to see? Oh, I know what the answer is. We are going to use physician extenders. So not only are we going to say you are covered, now we are not going to give you an experienced, gray-haired, reasoned, long-term educated physician with 25 or 30 years of experience; we are going to hand you off to somebody who is a nurse or a PA who is good at limited things but does not practice the art of medicine.

So I will wind up with this. I so want to fix health care. I am so sick of the way it is. But I am not near as sick of the way it is as the way it is getting ready to be under this bill. I know my patients are going to get hurt under this bill. My Medicaid patients are going to get hurt under this bill. My Medicare patients are going to get hurt under this bill. And those who are in between—whether it is with insurance with their employer or insurance they are buying on their own or they are paying cash—are going to pay more for their health care because of this bill. That is what I believe is going to be the outcome of this bill. And all you have to do is go look at the history. Talk to Alice Rivlin, the first CBO Director, about the accuracy of CBO in estimating anything when it comes to health care. They have missed it every way. They have only gotten one ''wrong,'' by saying it was going to cost more. For every other one, they said it was going to cost less than it did. So every patient—every patient—in some way or another is going to suffer under this bill. That is what we should be worried about. We should not worry about whether the President wins or we win.

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

Mr. COBURN. I thank the Presiding Officer for the accommodation of the time, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, how much time is remaining in this hour?

The PRESIDING OFFICER. Eight and a half minutes.

Mr. BAUCUS. Mr. President, I would like to yield 3 minutes to the Senator from Massachusetts. I have spoken with Senator SESSIONS. He is very kindly and very graciously agreeing that Senator SHAHEEN from New Hampshire will be able to speak next after Senator KERRY. So Senator KERRY for 3 minutes, and then the remaining 5½ minutes will be for Senator SHAHEEN.

I also unanimous consent that we be able to proceed until 3 o'clock under the usual form; that is, under the conditions of the last agreement.

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

Mr. BAUCUS. Mr. President, I yield 3 minutes to the Senator from Massachusetts. It is also my understanding that the Republican leader may come down at some point after Senator SHAHEEN speaks and use leader time. That is my understanding—or after Senator KERRY speaks. Whenever he comes, he comes. Thank you.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Mr. President, thank you very much, and I thank Senator BAUCUS for the time.

My friend from Oklahoma asked how many patients I take care of in terms of Medicare. I must say that is not the essential ingredient of being able to exercise common sense and to make some judgments about this issue. I could turn to him and ask, how many buses has he driven, but he votes on transportation policy; how many wars has he fought in, but he sends people to Afghanistan; how many courtrooms has he practiced in and tried a case in, but he is willing to limit attorney's fees. That is not the measure here. The measure is, what does the policy do?

Let me be very clear. The Medicare Advantage Program was put in place. It is a private plan that is run by the insurance companies. We put them in place, and they grew, in 2003, and gained the name ''Medicare Advantage'' because they were going to be run more efficiently and at lower cost. Originally, we were paying about 95 percent to the repayment, but that has angled up now to the point where MedPAC itself—not AARP. This is not AARP. This is MedPAC. Here is the MedPAC report. MedPAC says:

> Currently, Medicare pays Medicare Advantage plans 14 percent more than it would spend for similar beneficiaries in [the Medicare program], pays a subsidy of $3.26 for each dollar of enhanced benefits. . . .

So the Medicare folks are subsidizing additional payments to a program that is paying more than is regularly paid, and it goes straight to the insurance company. It does not make sense for tax dollars to be spent that way.

Finally, let me just say, the Senator referenced Massachusetts. Let me read a quote from the Massachusetts Taxpayers Foundation. It is the most conservative—it is constantly protecting the expenditure of tax dollars. Everyone in the State looks to it on issues of tax policy, expenditures. Here is what it says about our plan in Massachusetts:

> [T]he cost to taxpayers of achieving near universal coverage has been relatively modest and well within initial projections of how much the state would have to spend to implement reform, in part because many of the newly insured have enrolled in employer-sponsored plans at no public expense.

That is what happens.

The final comment I make to him: We are blessed to have five physicians in my immediate family—my daughter, my son-in-law, her father-in-law, and two nieces—and every single one of them would overwhelmingly disagree with the comments made by the Senator from Oklahoma. They hope we will pass this legislation, as do millions of other doctors.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, for the past several months, my office has responded to thousands of letters and phone calls about health care. I have traveled all across New Hampshire talking to small business owners and families who are desperate for help. I have talked to health care providers that are frustrated with the current system. The underlying message is very clear: Health care reform cannot wait any longer.

My colleagues on the other side of the aisle continue to offer amendments that would take this bill off the floor of the Senate, arguing we need to go back to the beginning and start all over or, worse, do nothing at all. But, Mr. President, you and I both know we need to act and we need to act as soon as possible. We need to continue to move forward. We need to move forward on behalf of thousands in New Hampshire and millions across this country who need health care reform.

I have listened to these families, these individuals, and I want to take a few minutes this afternoon to share two of their stories.

Judith Pietroniro from Francestown, NH, was diagnosed with breast cancer in 2005 after her doctor found a lump during a routine mammogram. After undergoing multiple surgeries and radiation treatment, I am very pleased to report that Judith is now in her fourth year of being cancer free. However, at a time in her life when she should be celebrating her good health, Judith is facing a new challenge—finding affordable health insurance—because, you see, when Judith was in treatment, she was fortunate to be covered on her husbands's insurance plan. They paid $82 a week for a family plan. Unfortunately, her husband lost his job last year. But the family has been able to take advantage of COBRA. However, when her COBRA option runs out, which is going to be at the end of this year, she will be unable to buy an insurance plan from her current carrier. That is because breast cancer is considered a preexisting condition until the patient is cancer free for 5 years under her plan. But the rub is, once she is cancer free for 5 years and able to qualify for insurance under her current plan, she will face a monthly premium of over $2,000 for a plan that has a huge deductible. Health care for Judith will simply be out of reach.

Now, Mr. President, you and I both know cancer does not discriminate. This could happen to any of us.

I also recently heard from Colleen Conners, a woman who lives in my hometown of Madbury, NH. Like so many others, she has struggled with our ailing health care system. She was born with a hip condition, and she has suffered from several other medical problems, including lupus and scoliosis. As a result, she has also been denied coverage because of her preexisting conditions.

I heard my colleague from Oklahoma talking about the people who he said were being denied care in other health care systems. But let me read what Colleen, my neighbor in Madbury, says about her situation under our health care system. She writes:

It's very difficult to be in this position. As a part-time lecturer at a college, I'm not eligible to buy health insurance through the system.

She says:

I was born with a serious congenital hip deformity and have incurred some 30, mostly related, surgical procedures to make it possible for me to walk and function with relative normalcy. It has given—

She names her insurer; I will not report that—

all the reason, it seems, to legally deny me the coverage I so desperately need. All other venues I have attempted to engage to secure affordable, sustainable, and efficacious coverage have similarly been denied me. I cannot tell you how hurtful this has been. The trickle down economics of my currently uninsured state has had a terrible impact on my daughter also, who just earlier today asked me, ''Mom, how long ago is it since your last mammogram?'' I told her, ''Five years, I think,'' to which she replied, ''Well, I've already lost one parent. I don't want to lose two.''

What is happening to people in New Hampshire and throughout this country is devastating to people like Colleen and Judith. But despite Colleen's struggles and the difficulties life has placed in her path, she has remained optimistic and hopeful that things will get better. I, too, am optimistic. I am optimistic we can pass comprehensive health reform that changes the way the insurance market works so my neighbors Colleen and Judith from New Hampshire and Americans in communities all across this country no longer face this discrimination.

The reality is we can't always control whether we get sick, and when we are at our most vulnerable moments, we shouldn't have to worry about whether we are going to be kicked off our insurance or whether our coverage is going to run out. Health care reform will offer this peace of mind to millions of Americans. Health care reform will touch the lives of all Americans.

We have the opportunity to improve our health care system for everyone in New Hampshire and across the country, and we must act now on this opportunity and pass meaningful, comprehensive health care reform.

I thank the Chair.

Mr. ENZI. Mr. President, I yield up to 20 minutes to the Senator from Alabama.

The PRESIDING OFFICER (Mr. FRANKEN). The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, I appreciate the comments that have been made about preexisting illnesses, and I do think we can do something with this legislation to fix that. We just have to be careful. If you have two people both making the same salary, they have both worked for 20 years, one individual saved and paid his health care insurance for those 20 years and got sick and is covered by it, and another one chose not to, it is not insurance if a person then walks in and wants somebody else to pay for it. But we can do that. I think we can work through those difficulties, and I would definitely support moving in that direction.

My colleagues earlier mentioned about Medicare Advantage, that this is a program some are critical of, and they think we can deliver health care better without the Medicare Advantage part of the Medicare Program. I would say Medicare Advantage can and probably should be reformed, but we shouldn't address the problems in Medicare Advantage by directly cutting its seniors' benefits.

With regard to the physicians, in my hometown of Mobile, the medical association ran a poll of their members and 94 percent of them opposed a government option which is in this bill, a part of this legislation. They opposed the bill in general in large numbers. A similar poll in Montgomery, AL, showed the same thing.

What I wish to talk about today is the Gregg amendment. The purpose of his amendment is to prevent Medicare from being raided for new entitlements and to use those Medicare savings, any that we can achieve, to save Medicare. I note for the record Senator GREGG, the former chairman of our Budget Committee and the ranking member on the Budget Committee today, is probably the most knowledgeable person in the Senate—not probably, I am pretty certain he is the most knowledgeable person in the Senate on the financial instability of Medicare. He has worked hard over the years to try to identify some way to fix it. A number of years ago he proposed an amendment, an idea that would have saved, over 5 years, $10 billion through cost effectiveness and smart actions within Medicare, and that $10 billion would have enabled the Medicare Program to extend its life. Because all the actuaries tell us—and there is no dispute about this—that by 2017 Medicare will be in default. Less money will be coming in than going out. So Senator GREGG saw that coming and he attempted to fix it. He was attacked by my colleagues on the other side for this $10 billion efficiency idea that would have strengthened Medicare, not spent it on something else, but he would spend it to strengthen Medicare. I do not think a single Member of the Democratic Party voted for it and several Republicans didn't. It was a tie vote. The Vice President had to break the vote.

The idea now that we are going to find $465 billion in Medicare savings without damaging the care and take that money not to strengthen Medicare and put it on a self-sustaining basis, as we should be trying to do, but to take it and create an entirely new entitlement program, is something I cannot support. Actually, I understand my colleagues in their speeches say they don't support it. They say they don't. They voted for the Bennet amendment which sort of seemed to say that. But we knew, those of us who read it carefully, that the amendment of the Senator from Colorado wouldn't do anything. Even the New York Times which supports this bill said it was a meaningless amendment.

So let's talk about where we are. The Gregg amendment, unlike the Bennet amendment, means what it says. This is a serious vote. It simply says if you

take money from Medicare, it ought to be used to strengthen Medicare, not to create a new program with it. It is pretty clear about it. It has teeth. It means what it says. It is not a joke. It is not a flimflam. It is a serious amendment. So we will now be, I think, ascertaining how people in this body actually believe with reference to Medicare and whether we ought to be taking money from it.

The amendment says if non-Medicare savings—which are very few, if you want to know the truth—if the non-Medicare savings in this proposal do not offset the new cost of this new bill, the Secretary of the Treasury and the Secretary of HHS are prohibited from implementing new spending or revenue reduction provisions in the bill. The reality is there are not going to be any—or very few say non-Medicare savings. That is where the savings are, frankly.

The amendment prevents Medicare cuts from being used to create new and expanded entitlement programs and to fuel massive government growth on the backs of Medicare beneficiaries. I recall for my colleagues that people who pay into Medicare have paid into it all their lives and they are now at a point in their life where they are drawing from it. The social contract we had with them was that they would pay into this program, and when they got to be 65, they would get the benefits from it. They didn't get the benefits of it when they were 30. They didn't get the benefits when they were 40. They didn't get the benefits when they were 50, yet they were paying in all these years, and now when the time comes to benefit from it, we have a massive plan to raid that program that clearly is the most unstable, actuarially unsound program we have in our country. It is heading into default. When it goes into default, it is not going to gradually go beyond the break-even line; it is going to drop below it dramatically. It accelerates. One study from the Heritage Foundation, I believe, said as much as $80 trillion over the lifetime of instability in this program. So I don't think anybody disputes the numbers and the problems that Medicare faces.

The bill says we are going to have a budget-neutral piece of legislation here, and don't worry, it is not going to add to the debt. In fact, we are told by the President that not one dime will be added to the debt. We have Members of this body who say the bill on the floor will create a $130 billion surplus over 10 years. Well, that would be good if it were true. How do you do that? Well, there are a number of things, but one of them is you have a $494 billion tax increase, and an $848 billion fund achieved largely from Medicare. That is where the $465 billion comes from: Medicare. But the truth is that is not an accurate number, because the tax increases start immediately and the benefits don't start until 2014, 5 years down the road, the fifth year. When you add that up and you take the first 10 years of the real implementation of the legislation that is on the floor, it is going to cost $2.5 trillion. That is a big amount of money.

Also, it does not fix the doctors payments that everybody assumed and thought and we were told would be part of health care reform. That is not done. Why is it not done? Because the bill wouldn't balance. You wouldn't be able to tell the American people that it brings in revenue when it doesn't. That is $250 billion to fix an essential payment to our doctors that we cannot cut. We need to put that on a sound financial basis. It should be a part of this reform. But since they couldn't—they figured they had raised enough taxes and they couldn't claim to cut anymore from Medicare, they put it out here on the side somewhere and we will do as has been done in the past, unfortunately: Pay the doctors their payments by increasing the debt. Every penny of the money that goes to make up the shortfall in doctor payments increases the debt and it is going to continue and it should end.

The bill is not balanced in any fair analysis. It is a shell game. It moves the $250 billion shortfall for doctors out of the bill. They say we don't have a problem, our bill balances. But there is a $250 billion hole sitting over here; we just moved it across the room here. That is not good and sound policy.

The Gregg amendment prohibits the using of the $465 billion in Medicare cuts to pay for the new government spending in this legislation. It would keep the Medicare expansions—Medicaid expansions from going into effect without—by having or saving cuts in Medicare or Social Security. Unlike the Bennet amendment, which had no meaning whatsoever, it has some teeth to it. So we will know something significant about how people feel about Medicare and the financial responsibility when this vote comes up.

Senator BENNET has said:

> With my amendment, the bill strengthens Medicare and preserves seniors' benefits.

Well, I think that is not an accurate statement. Once and for all, with this amendment, we will be able to show American seniors who have paid into their health care—Medicare—all their lives, that we mean it when we say we don't want to weaken their program.

One asks, how can you have such a disagreement, Senator SESSIONS? Look, you might ask me, they say the money is there; you say you are cutting Medicare; they say it is not cutting Medicare, $465 billion. Somebody ought to be able to get it straight here. How can you possibly have this kind of disagreement? I say to you the general fund budget for the State of Alabama—we are about one-fiftieth of the Nation's population, 4 million people, it is about $2 billion. So how can we lose $465 billion? Well, this is what they are saying. If you listen to much of the comments carefully, they are saying: We are not cutting guaranteed benefits to seniors. They are not saying they are cutting Medicare, if you listen to most of the people who are careful about what they say. They say, We are not cutting guaranteed benefits.

I see. What are we doing?

We are cutting home health care agencies; we are cutting hospice programs; we are cutting hospitals; we are cutting the disproportionate share hospitals for poor people; we are cutting program after program after program. So they are cutting the providers and telling everybody we are not cutting Medicare. But if we are going to cut providers, why haven't we already done it and put Medicare on a sound footing? You can't cut providers this much. You cannot do so. They will collapse. Doctors already are refusing to take Medicare patients and they are worried about that. I think in the future, if we go through with this legislation, we will see far more will quit seeing those patients.

Well, the Gregg amendment makes sure Medicare savings go to making the program more solvent and not to offset the creation of an entirely new entitlement program. There are many things we can do in this legislation to improve health care in America. I know many on our side have offered many things, some of which are in the bill, many of which are not, but we can do a lot of things together that we could agree on that would strengthen and make health care better in this country.

This legislation is unsound. We will be raiding Medicare. We will have a massive, new tax increase. If we were going to raise taxes, let me ask, might that money be best spent to make Medicare solvent instead of creating a new program, when we know Medicare is going to be insolvent in just a few years? We will be raising taxes and creating bogus, phantom cuts in Medicare, and they claim that will make this bill balance. They are adjusting the numbers in the bill so the benefits don't start for 5 years, to make the first 10 years look like it is a sound program—looks like it is going to cost $848 billion for the first full 10 years of implementation, and it costs $2.5 trillion.

There is not nearly enough money to pay for that. We are just going to be increasing the debt. That is why the American people have noticed. They have been out there at tea parties and meetings and rallies, pleading with us to be responsible, to quit throwing away money, quit acting like there can be something for nothing. There can't be something for nothing. Somebody has to provide care if we say care will be provided. If they provide it, it has to be paid for. That is simple.

We are creating a mindset that has resulted in a budget from the President that will double the entire national debt in 5 years and triple the national debt in 10 years. The national debt—$5.7 trillion last year—will go to $11 trillion-plus in 5 years and $17 trillion in 10 years. That is unacceptable. It is irresponsible. We need to listen to our constituents and respond to their commonsense pleas that we act with more

responsibility in the Senate. I thank the Chair.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mr. PRYOR. Mr. President, I am here to speak on my amendment, which is a simple and straightforward amendment to create an enrollee satisfaction survey for the qualified health plans offered through the exchange established in the Senate health care reform bill. Let me show you how this will work. This is taken from the Federal Employees Health Benefits Program Web page that is administered by the Office of Personnel Management, OPM. They lay out on the Web page how the survey works.

The first question is:

How would you rate your overall experience with your health plan?

Other questions are:

When you needed care right away, how often did you get care as soon as you thought you needed it?

How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?

This is all collected and put into a form and used when people make health care decisions on what plan to choose. One of the real measures of the quality of a health care plan is how satisfied people are with that plan. It is a little bit hard to measure. We send out these surveys to Federal employees. They come back and the information is available to the public. People can click on this and know, when they are about to sign up for a plan, how the plan rates in satisfaction.

This is not a new idea. It has been around for a long time. It helps people make good health care decisions. It allows them to compare one company to another. It allows them to look at what the people who have that health care plan right now, how they perceive the performance of the plan. It is a win-win for the whole system.

The idea is to make this part of the new law, and if you are on the exchange, you would have access to filling out one of these surveys; but, more importantly, you would also have access to reading the surveys and knowing, when you are making your health care choice, how your company rates. Here are a few examples.

Again, this is from the Web page right now under the Federal health care plan. The first question was about overall plan satisfaction. The FEHBP national average is 80 percent. People are 80 percent satisfied with that. There is one insurance company that only has 54.5 percent. Another one has 88.7 percent. So you can understand the range. Again, that is not to say nobody is happy with that one at 54.5 percent, but it allows the people who are purchasing the health care to make an informed decision before they enter into a contract with the company.

One of these categories is ''getting care quickly.'' The average is 91.6 percent. It is not a big spread, but one company is at 88 percent, a little below average. The highest company is at 93.5 percent, a little above average. That is not a very big spread, but if getting care quickly is your most important thing, you may want to go to the one where the people who use that insurance company right now say you get care the quickest.

Another issue is the claims processing. That is one of the questions here: How does a company do in processing your claims? In our office, we have hundreds of complaints from people around Arkansas who have had problems with insurance companies processing their claims. Again, the average here is 92 percent. That is what the FEHBP average is. There is a company that has a 77-percent rating as a result of the survey. There, again, that is not saying people would not choose that company; they may choose it for other reasons. But if the claims processing part of their business is important, they may not choose that company, or at least they know what they are getting into. The highest one I saw in the claims processing was 96.8 percent.

You understand this is something that already exists, something I cannot imagine anybody having a problem with because it puts the tool in the hands of the people making decisions on the health care provider that they are going to choose. It puts the tool in their hands, before they choose them, to know what they are getting into.

Lastly, basically, this doesn't cost any money—and if it does, it is just a tiny amount. This is a very consumer-friendly tool. It simplifies the process for people. It takes a lot of anxiety out of the process for people. It is also a very good commonsense, grassroots way to hold insurance companies accountable. If they don't do well in these customer surveys, chances are they will not get a lot of business in the coming year. It puts a quality control there—a satisfaction-based quality control there. I think it is a great tool for keeping people happy. I can guarantee you that, when they look at the survey from this company that only had 55 percent respond in a positive way, they are going to talk to their folks and say: We have to get that number up. What is going on in this company?

Again, this is something people talk about. I have heard many people in Arkansas and around the country say they want the same deal we have in Congress. This isn't all the same deal, but this is part of it. What we are able to do is, when we make health care choices, we are able to have this knowledge before we make a decision. Accountability and performance go hand in hand. This is a great example of how we can do that and have a very inexpensive way and a way that is meaningful to the people making the decision. This is there at the point of decision.

I ask that all my colleagues join in this amendment. We will vote on this, I understand, around 4 o'clock.

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

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

Mr. PRYOR. Mr. President, I ask unanimous consent that the time during the quorum call be charged equally between the two sides.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. ENZI. 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. ENZI. Mr. President, I allocate the balance of our time to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. DURBIN. Mr. President, before the Senator speaks, I ask unanimous consent to follow the Senator from Tennessee.

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

Mr. CORKER. Mr. President, how much time is there on the minority side?

The PRESIDING OFFICER. There is 12 minutes.

Mr. CORKER. Mr. President, I may not take 12 minutes, I tell the Senator from Illinois so he may plan his time.

I am here to speak regarding the Gregg amendment. This health care debate, in many ways, has been going on the better part of this entire year. There are obviously differences in this body over philosophical issues and how health care needs to be delivered.

One of the things I hope has come across is that all of us would like to see health care reform. I campaigned on health care reform. I used to be commissioner of finance for the State of Tennessee. In that particular role, I oversaw the Medicaid Program, which is called TennCare. I saw, firsthand, the tremendous plight of people not having appropriate health care and what they deal with on a daily basis. When I ran for the Senate—and I have been here 3 years now—I ran on the whole notion of health care reform.

I have put forth numerous ideas during my first Congress, authored with others bills that I feel would have delivered health care in an appropriate way to citizens across this country. The other part of the debate, though, is not just philosophically how that is done—and we have had a lot of give and take on that—but it has been the issue of paying for something such as this.

Early on, I sat down with the chairman of the Finance Committee. I have met ad nauseam with people on both sides regarding health care insurance and sent to the majority leader of the Senate a letter, signed by 36 Senators, to this effect: We all want to see health care reform.

But we also want to ensure that the entitlements that are in place, and in particular in this case Medicare, are on a sound footing. We want to make sure those commitments we have made to seniors and future seniors will remain in place. And we want to make sure our country's fiscal condition is on solid footing.

I could go into discussions about how we are perceived around the world as relates to our financial situation. I could talk about the value of the dollar. But I am going to speak about the one issue the Gregg amendment addresses, and that is keeping integrity in the Medicare Program.

I believe the Senator from Illinois, who is going to speak in a moment, and myself would be much closer in this debate had we not begun with a fundamental building block of this bill using $464 billion in Medicare ''savings,'' to leverage an entirely new entitlement. For me that was an absolute nonstarter. I know for Senator ENZI from Wyoming it was an absolute nonstarter.

We have a number of differences, but the fact that we would raid a program we all know is insolvent, that has $38.6 trillion of unfunded liabilities, that we know is going to end up creating havoc for our country if we do not deal with it, the fact that we would take savings from that program, which is insolvent, and use it to leverage a new entitlement, in my State and I think most States around the country, does not pass the commonsense test.

People have lined up on both sides. My friends on the left certainly see this possibility, and certainly I am in no way implying any agenda issue, but this has become a political issue. The President obviously was over here yesterday advocating that everybody stick together and pass this bill. This one amendment we are getting ready to vote on this afternoon to me defines much of this debate; that is, are we truly as a country going to take $464 billion in savings from an insolvent program that everyone knows is insolvent and use that to leverage a new entitlement, that even when it begins is insolvent also? If you look at 10-year costs versus 10-year revenue, we know that over time, this new entitlement that might be created by this bill is also going to have tremendous fiscal implications to our country.

One of the most offensive pieces of this legislation is not only will we be taking this $464 billion—and I realize the Senator from Illinois mentioned yesterday on the floor the fact that some of the things that are in this bill will lengthen the life of Medicare. I understand how the math works on that. I do. I understand that. But I think the fact that we would take, again, savings from a program that is an entitlement that people count on, that seniors count on and that future generations—these young people sitting before us on the steps, these wonderful people who have come here to help us—are going to ultimately be stuck paying for, taking that money to create a new entitlement, to me, does not make sense.

The offensive part I was going to allude to is not even dealing with the SGR, the doc fix. This pays for the doc fix, or SGR, for 1 year. For those who are listening and don't know what that means, it means that physicians who deal with Medicare recipients for 1 year will not receive a 21-percent cut in reimbursements. But the very next year, there is going to be a 23-percent cut to physicians who serve Medicare recipients.

This bill, instead of taking those savings and dealing with that—and over a 10-year period that would cost $250 billion, I might add—instead of dealing with that, we are going to throw that off to the side and use the $464 billion to create a new entitlement. I do not know how anyone in this body can talk to their constituents or talk to any of us with a straight face and say that is a sensible thing to do.

All of us know we have huge deficits, and even though we disagree about much of that, the stimulus, and other issues that are happening, the thing that we agree on is our country has some long-term issues that need to be dealt with. It seems to me we would show people around this world who loan us money and certainly show our citizens back home that we have the courage to deal with those entitlements.

I am hoping we are going to have an opportunity to vote on a task force, a commission that will have a binding ability to cause us to deal with Medicare and Social Security in a defined amount of time very soon. But it seems to me the first huge step for all of us is to vote for the Gregg amendment today.

I realize that if the Gregg amendment is adopted, the construct under which this entire health care reform bill is based would dissipate. I realize that. I realize we are creating a health care bill from something that is insolvent, taking money from it to create something that, again, will be insolvent.

What I say to my friends on the left is I stand ready to talk about solutions. I have proposed solutions. I don't know how anybody in this body can with a straight face say we are being responsible as it relates to Medicare as an entitlement if, in fact, Members of this body do not support the Gregg amendment which would keep this savings from being used for a new entitlement and instead would lock it away in a manner to make Medicare more solvent for generations to come.

I thank my colleagues for the time. I do believe it is the initial building blocks, the fundamentals of this bill that have kept us apart. I realize there are some emotional issues that separate Members of this body, and my guess is that Senator REID, in his managers' amendment, in working with Senator DURBIN and others, will figure out a way to resolve this issue. I know there is the issue of the public option. My guess is that will be figured out in some form or fashion on the other side of the aisle. There are other issues that I know are emotional that divide us. But the fundamental building blocks of this bill are flawed. They are flawed. It is this very issue, plus a couple of others, that has kept this body from being able to work together and has made this debate a very partisan debate. I regret that.

I hope my friends on the other side of the aisle will over the next few days realize this is not something of common sense, this is not sensible. I hope they will reconvene and I hope that we together can focus on something that will stand the test of time instead of kicking the can down the road, knowing full well this is incredibly irresponsible.

My guess is—and I would love to hear the Senator from Illinois dispute this—if this bill were to pass in its present form, that within a week or two, the majority will take up the issue of paying for the doc fix or not paying for it, but actually passing legislation to basically throw debt on these young men and women sitting in front of us.

My guess is if this bill passes, the majority party will say: Oh, we have to deal with the doc fix; we have to deal with SGR. By the way, that is a $250 billion tab. My guess is the majority party is going to bring legislation forward in the next 2 or 3 weeks to deal with that—or maybe not in the next 2 or 3 weeks. I guess since we have a 1-year—within the next year the majority party will bring something forth to deal with this issue and point back to this moment of disingenuous activity on this floor. I hope that is not the case.

I thank all involved. I know this has been a very vigorous debate which I hope will carry on until we get it right. But I am very disappointed that the fundamental building blocks of this bill have separated us. I hope this body will stop what it is doing in regard to Medicare, come together, and do something that stands the test of time.

I realize my time is about up. I do not want to cause the Presiding Officer to tell me that.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. How much time is remaining on the Democratic side?

The PRESIDING OFFICER. Nineteen minutes.

Mr. DURBIN. Mr. President, I thank the Senator from Tennessee. Although we disagree on this issue, I respect him very much. I am hoping—maybe it is a false hope—before the end of the day,

he will join us and make this a truly bipartisan effort. We have tried, we have reached out to the other side of the aisle for almost one calendar year with lengthy hearings in the HELP Committee, in the Finance Committee, inviting Republican Senators to come join us.

There were times when there was kind of a tease that was going on where they would come in and offer amendments and the amendments would be adopted in the HELP Committee. I think over 100 Republican amendments were adopted. We felt they were coming our way, that we were going to have a bipartisan bill. Then the roll was called and not a single Republican Senator would vote for it.

As I stand here today, after 1 year of effort, despite three committees in the House going through markup, two committees in the Senate, despite the vote on the Senate floor, the official tally is this: Only two Republicans have voted for health care reform. One Congressman from New Orleans, LA, a Republican Congressman, voted for the House bill. One Republican Senator, Senator SNOWE of Maine, voted for the Finance Committee bill to be brought from the committee. We have made a good-faith effort. We will continue to.

I salute the Senator from Wyoming who is on the floor who is the ranking member of the HELP Committee. I know he spent long, arduous allocations of time meeting and trying to find a bipartisan solution without success. But thank you for trying.

I say to the Senator from Tennessee, we would like to have your support. We would like to have your help in passing this bill and truly making it bipartisan. That is our goal, and I hope it happens.

The Senator from Tennessee questioned the fundamental building blocks of this bill. I cannot resist the opportunity to say I think this is a good bill, and I believe the effort that went into it by Senator DODD, who has now joined us, and the HELP Committee and Senator BAUCUS and the Finance Committee gives us a bill that has many positive things.

This is our bill, 2,074 pages. It is the Democratic reform bill. You will see the desks on the other side of the aisle are empty because they do not have a bill. The Republicans have not produced a health care reform bill. In 1 year of speeches and press releases and charts and appearances on television talking about health care reform, they have not produced a comprehensive health care reform bill. I know why. It is hard. It is very difficult to tackle one-sixth of our economy. We did it, and it took a lot of effort, as I mentioned earlier.

Second, there are some in the Senate—not on this side of the aisle—some in the Senate who do not believe we need to change. Some accept the current system. I think if they accept it, then they have to answer a few fundamental questions about the building blocks of this amendment. If the Republican Senators who oppose our bill accept the current system, what do they have to say about the affordability of health care premiums?

We know what has happened. Health care premiums have risen dramatically. Ten years ago, a health insurance plan for a family of four was $6,000 on average. Today it is $12,000. We project in 8 years it will be $24,000. If we do not stop this, fewer and fewer Americans will have health insurance, and what they have may not be any good.

We have in this bill efforts to reduce the increase in costs in health insurance premiums. Don't take my word for it. The Congressional Budget Office, which is the official umpire, has said, yes, the vast majority of Americans will see their health insurance premiums either go down in cost or not go up as they would have. So we address, No. 1, the affordability of health care for businesses and families across America. There is no Republican bill that does this.

Secondly, the provisions in this bill will extend protection of health insurance so that 94 percent of Americans will have the peace of mind of knowing they have health insurance. Thirty million more Americans uninsured today will have health insurance. Of the lowest income categories, some will qualify for Medicaid, the government program for the poor and disabled, and in other instances some will qualify for the health insurance program, but they will have protection—30 million more Americans. There is no Republican bill or amendment that extends coverage of health insurance to 30 million more Americans. There is none.

There is a third issue, too. We have built into the front end of this bill what we call the health care bill of rights. It is about time somebody stood up for families and individuals across America who have been treated very poorly by health insurance companies. These extremely profitable companies make a lot of money by saying no—saying no to your doctor's recommendation for surgery, saying no to your doctor's recommendation for the appropriate medication. They have people who just say no. But here is what our bill does. Our bill says that in America you will have the right to buy insurance if you have a preexisting condition.

What that basically means is the No. 1 reason that health insurance companies deny coverage today is going to come to an end. We are creating new risk pools where preexisting conditions cannot exclude you. I know everyone is concerned about that critical moment in time when there is a frightening diagnosis or a terrible accident that they will turn to their health insurance they have paid into for a lifetime and the company will say: No. We checked your application and you failed to disclose something about your past medical history—such as acne. Incidentally, that was one of the reasons used to refuse coverage. So the first thing we do is make sure that Americans have the right to buy insurance and won't be excluded for preexisting conditions.

We also make sure you will be able to keep your insurance if you become sick or injured. Too many times when you get sick, your insurance fails you. Two out of three people filing for bankruptcy in America today file because of medical bills they can't pay—two out of three. And 74 percent of them had health insurance. They thought they had protection—they paid the premiums—but when they needed it, it wasn't there. So the No. 2 element in our health care bill of rights in this bill is that you can keep your insurance if you become sick or injured, that your insurance won't face lifetime limits on coverage, and that you will have affordable insurance if you lose or change your job. That is a large portion of the uninsured people in America.

Here is one that parents will appreciate. Remember when you first learned when your family policy wouldn't cover your son or daughter, right as they were coming out of college? And you thought: Uh-oh, they are loaded with student debt, they are looking for a job, and now they don't have health insurance. I can't tell you how many times I called my daughter and said: Jennifer, have you got health insurance yet? Oh, yeah, dad, I will get to that soon. I didn't like to hear that. Parents don't like to hear that. Well, we extend them from age 24, and we say they can stay on their parents' insurance policy until they are 27. That is an addition of several years of protection—peace of mind—while a young person goes about finding a job, starting a career, and starting a family.

We also provide preventive care without extra cost, and we also begin to eliminate the discrimination in health insurance premiums. Health insurance companies—insurance companies in general and health insurance companies—are the only business, save American baseball, that is exempt from antitrust laws, which means they can literally come together—the executives of the insurance companies—and decide how much to charge in premiums for women, the elderly, people who are members of a minority group, and they can make those distinctions and do it legally. We put an end to that. We say you have a right to fair insurance premiums without discrimination based on gender, health history, family history, or occupation.

There has not been a single Republican bill offered that offers this patients bill of rights to make sure we have this kind of protection when it comes to health insurance. It is one of the fundamental building blocks when it comes to health care reform in America.

The Senator from Tennessee and others have raised the question about deficits and have said: Well, isn't this bill, for all that it seeks to do, going to add more expense to our deficit? That was a legitimate question, asked by President Obama when he told us: If you want to do health care reform, don't do it at the expense of adding to our debt as a nation.

When we passed the prescription drug bill under Medicare—when there was a different party in charge in the Senate and in the White House—they added $400 billion to the deficit and didn't blink—$400 billion in debt added to America with impunity. It meant more subsidies for pharmaceutical companies—which do quite well—and more subsidies for health insurance companies—which are very profitable—at the expense of our deficit.

Now when it comes to this bill, that same party has returned to its role as the deficit hawk. Well, they should look very carefully at this bill, because the Congressional Budget Office tells us this legislation will reduce the deficit of the United States by $130 billion over the next 10 years, and in the following 10 years there will be $650 billion in reduced deficit. That is almost $1 trillion in deficit savings over 20 years.

There is no bill that has ever been introduced that makes this kind of deficit savings, according to the Congressional Budget Office. And unfortunately for their argument, there is not a single bill before us on the Republican side of the aisle which would even come close to reducing the deficit in that regard. In fact, all the major amendments that have been offered so far on the Republican side of the aisle add to our deficit. They want to continue the subsidy for private health insurance companies under a program called Medicare Advantage.

The Senator from Connecticut has said repeatedly—and I hope he will say again soon—that Medicare Advantage is neither Medicare nor an advantage. It is a subsidy from taxpayers to profitable health insurance companies, which the Republican side of the aisle has labored day after day to protect—a private subsidy to health insurance companies. The health insurance companies can't stand this bill because it upsets their apple cart and maybe their profit and loss statement, and they can't stand the thought of having Medicare Advantage policies held to accountability or losing the subsidy they currently have. But we believe that if we are honest with Medicare and its future, we have to do that.

I want to address one issue that comes up every time my colleagues on the other side of the aisle stand to speak, and it is the issue of the future of Medicare. They fail to recall that Senator CORKER, from Tennessee, Senator DODD, myself, and the Presiding Officer all voted in favor of the amendment offered by Senator MICHAEL BENNET of Colorado. The amendment that he offered—which is the most bipartisan amendment we have had on this otherwise partisan bill—said nothing we do here in this bill will in any way reduce or endanger guaranteed benefits under Medicare, No. 1. And, No. 2, any savings that we get from this bill under the Medicare Program have to go back into putting Medicare on solid financial footing, to extend the benefits available to seniors, and to reduce the cost to seniors.

We all voted for that. It is now a part of the law we want to pass. So to come to the floor and argue the opposite is to ignore their own votes on the issue. Senator BENNET of Colorado has passed a watershed amendment that every senior and the families of seniors should respect as important to their future. So although you may disagree with the fundamental building blocks of this amendment, I think they are sound, I think they are responsible from a fiscal viewpoint, and they are responsible when it comes to the future of Medicare.

Mr. DODD. Will my colleague yield?

Mr. DURBIN. Mr. President, I will be happy to yield, and I will be glad to yield the floor, if the Senator from Connecticut wants to speak.

Mr. DODD. No, no, but I certainly like these moments where we engage a little bit.

Mr. DURBIN. It is perilously close to debate here in the Senate.

Mr. DODD. Be careful about that. The last thing you want to have is a debate here. We used to have them. It doesn't happen often enough these days.

A couple of points you made can't be reinforced enough. One of the great worries, obviously, is the cost issue. I think everyone agrees this is the great nightmare we have, the growing problem of cost—the premium costs. Again, we either love or hate CBO depending on what numbers they come back to us with. I have been on both sides of those emotions when dealing with CBO, but we have come to recognize and accept the fact—I think collectively here—that we rely on them. This is not Mount Olympus, not to say they are 100 percent right on every occasion. But I was going over the numbers, and I wondered if my colleague from Illinois—I know he is aware of these, but I may be wrong on some of this.

If you take the individual market in the country, there are 32 million people under CBO's analysis that are in the individual market. They would pay, according to CBO, 14 to 20 percent less in premiums of an equivalent plan than under the status quo. In the small group market, there are 25 million people, according to CBO, who fall into the small business market—the small group market, and the ones who are eligible for tax credits would pay 8 to 11 percent less in premiums than for an equivalent plan under the status quo. If you work for small business and don't qualify for the tax credit, your premiums would be about 2 or 3 percent lower. So you go from 8 to 11 percent to 2 or 3. And, lastly, where most people are—where five out of every six people work, in the large group market—people who work for large employers—roughly 134 million people, according to CBO—would see lower premiums up to 3 percent than what they pay under the status quo.

That, to me, goes to the heart of this. Obviously, getting down and reducing our budget deficit by $130 billion, $150 billion the second decade, is terribly important. But if I am sitting out there as a consumer and I want to know one thing more than anything else—how is this going to affect me; am I going to be paying more or less—as the Senator points out, we are now looking at the year 2000 in Connecticut where a family of four paid between $6,000 and $7,000 for health care and they are now paying $12,000, the same family, and in the next 7 years they will go to 24,000, and some predict within 10 years going to 35,000. Those are staggering increases.

Compare that, if you will, with what we are being told, even if these numbers are off a little bit, and they may well be one way or the other. But assume for the sake of debate they are not off quite that much; they may almost be flat, the cost; not actually a reduction in premiums. I can't understand why people wouldn't embrace this in a wholehearted fashion and say this is a great achievement. No one has been able to improve these numbers.

Am I wrong about some of these numbers, or are those your calculations as well?

Mr. DURBIN. As a matter of fact, the Senator from Connecticut, I would say through the Chair, is quoting a study from the Congressional Budget Office requested by Senator BAYH of Indiana, who asked the straight-up question of the Congressional Budget Office: If this is passed and becomes law, what will happen to premiums to people across America? As the Senator from Connecticut correctly reports, the premiums are either going to stay the same or go down for the vast majority of people; otherwise, they are going up dramatically.

There is one other element, which I know the Senator is aware of. If you happen to be one of those callous, styptic-hearted individuals who could care less about people who are uninsured, believing the poor will always be with us, you ought to stop and reflect upon the fact that many of the poor people with no health insurance receive medical care through charity, compassionate care from hospitals and doctors, and their costs are passed along. We estimate that current premiums reflect about $1,000 to $1,200 a year that each of us pays—in addition to what we need to cover our families—to cover those uninsured who receive the benefits and the treatment they seek at hospitals.

So in addition to reducing the premiums, as the Senator from Connecticut said, as more and more people

come into coverage with their own health insurance, there is less of a pull on our benefit packages to subsidize the uninsured.

Mr. DODD. One other statistic that again jumps off the page at you, and I went back to my staff and said: Are you sure these numbers are right? I am told they are correct. For people who receive tax credits—and many do under our proposal here—the premium savings, on average, are 56 to 59 percent lower relative to the current individual market premiums—56 to 59 percent lower.

That is an incredible achievement in a piece of legislation designed to deal with cost—how do you get costs down? And of course the added elements of this—which again CBO doesn't calculate in showing reductions in premiums—include catastrophic options available to young adults, reinsurance provisions, which would reduce premiums even further. None of those calculations were actually calibrated by CBO in arriving at their conclusion. So, actually, I think these numbers turn out to be far better than the ones we have just talked about.

Mr. DURBIN. I say to the Senator from Connecticut, this affordability element is the No. 1 reason why we need health care reform, and I think the one reason why our critics on the other side of the aisle come to this debate emptyhanded. They don't have anything to offer to reduce the costs. We are looking for a comprehensive bill from the Republican side.

This is ours, and it has been on the Internet for over 2 weeks. Every word can be read by every person in America. That kind of transparency and disclosure is what we need in the course of this debate. I am sorry the other side doesn't offer an alternative but does offer, unfortunately, amendments which don't enhance this bill's goals.

Mr. DODD. If I could get a last minute on the floor, Mr. President, I commend Senator MARK PRYOR, our colleague from Arkansas, whose amendment we will vote on shortly. I commend him for his work. This is a very worthwhile amendment he is offering, and gives individuals and small businesses better and more consistent information about insurance plans that would be sold in the exchange. All of us in this Chamber, and every Federal employee, gets one of these. This is a little booklet. What it says is: ''Guide to Federal Benefits.'' I think I get some 15 or 20 options this year. I get options—take a look. I can open this book to various pages, and there is a comparative analysis of consumer reactions to the various plans over the last year or so, what they thought of them, how well they worked. There is nothing similar to this. We put language in our bill out of the HELP Committee to try to put this in common language people can understand, getting away from the small print, telling people what exactly will be the benefits under their plan, or the disadvantages, to some degree. The Pryor amendment includes this kind of provision in the bill and strengthens it tremendously. I commend Senator PRYOR of Arkansas for including a provision in this bill that will provide greater clarity and greater understanding, the same kind of clarity we get under the Federal Employees Health Benefits package that allows us to make that very simple. You don't have to have a Ph.D. in economics to understand this. You can go right through and they list it quickly, if it is only yourself, yourself and your family, what it is like in Delaware, the District of Columbia, Florida, Georgia, every State. It is a very simple, very clear understanding of how this works.

One of the complaints all of us get all the time, this is complicated. No matter how sophisticated you may think you are, trying to sort out what is the best plan for you—and I say this candidly, the insurance industry isn't always as forthcoming in letting you know what the disadvantages are as they are marketing their various plans to people. So the Pryor amendment, I think, will go a long way toward providing that kind of clarity and understanding that all Americans want. I urge my colleagues to support the Pryor amendment when that issue comes up for a vote.

I see the time is 3. I inquire and see I have gone over a little bit past 3 o'clock. I apologize to my colleague.

Mr. DURBIN. I ask unanimous consent that the next half hour, between now and 3:30, be evenly divided as the time has been before and the first person recognized on the Democratic side in that slot be the Senator from Washington, Mrs. MURRAY.

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

Mr. DURBIN. And that the same other conditions will apply as the previous unanimous consent.

Mr. CORKER. I wonder if the Senator from Illinois will yield for a question.

The PRESIDING OFFICER. Does the Senator from Illinois yield?

Mr. DURBIN. Relative to the unanimous consent request?

Mr. CORKER. No.

Mr. DURBIN. I have pending a unanimous consent request.

The PRESIDING OFFICER. Is there objection to the request? Without objection, it is so ordered.

Mr. DURBIN. I will be happy to yield and ask our time be evenly divided, but I wish to give the Senator from Washington a chance to speak for a few moments too.

Mr. ENZI. I think we are in alternating modes, so I could yield some time to the Senator from Tennessee.

Mr. CORKER. I listened to the Senator from Illinois talking about Medicare, and I assume, based on his comments, there is a chance we may get a 100-to-zip vote on the Gregg amendment, which truly ensures that all Medicare savings are used to make sure Medicare is more solvent.

The Bennet amendment, as I think the Senator knows, was parodied in the New York Times over the weekend, talking about it as toothless. It was a cover vote to give people the opportunity to be able to say they voted for something that saved Medicare, but actually the Gregg amendment does that. It puts the money away in such a fashion that all savings that are derived from Medicare are used to make Medicare more solvent. I am assuming that, since the Senator from Illinois is so supportive of ensuring that occurs, that he will be supporting this amendment.

Mr. DURBIN. If the Senator from Tennessee is propounding a question, I will be opposing the Gregg amendment. I think the Bennet amendment achieves what we wanted to achieve. I think my friend from New Hampshire in his amendment goes too far and, basically, we understand what he wants to do. He doesn't want to see us create tax credits to help families pay for health insurance premiums. He believes it is an entitlement. I think your side referred to it as such. I think it is important to help businesses and individuals who are struggling to pay health insurance premiums receive some assistance in doing so.

Mr. CORKER. So what the Senator from Illinois just said is the answer is no; that they are willing to use Medicare savings to create a new entitlement and they are not willing to do something that absolutely locks away those savings so they can only be used to make Medicare more solvent. I think all of us know the Bennet amendment was a cover vote. Nothing around here that has any meaning passes with 100 votes, with 58 Democrats, 40 Republicans, 2 Independents. The fact is, the whip on the other side of the aisle, whom I respect and who is very eloquent, has just said that, yes, we are willing to raid Medicare and to take the savings from that, an insolvent program, to create a new entitlement or a new program—whatever you want to call it; I don't want to be pejorative—that is also going to be insolvent the day it starts, but, yes, we will take Medicare dollars directly. We will not do what Senator GREGG wants to do; that is, to be responsible, to try to make it solvent. We are going to lever it for a new entitlement—or a new program, whatever you want to call it—and I think, by virtue of this vote, we will see who in this body is serious about truly wanting to save Medicare for seniors and making sure young people are not hocked to the hilt in the future.

Mr. ENZI. Mr. President, I reserve the remainder of our time for the Senator from New Hampshire, but I will allow the Senator to speak now.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, I come to the floor this afternoon, although I know this is an extremely important issue we are debating, health care, but I wish to speak on a different topic.

(The further remarks of Mrs. MURRAY are printed in today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. How much time remains on both sides?

The PRESIDING OFFICER. The minority has 13½ minutes; the majority has 1 minute 8 seconds.

Mr. GREGG. I yield 11 minutes to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, opponents of the Gregg amendment claim the Reid bill doesn't technically change the law on guaranteed benefits for beneficiaries. But they are ignoring the fact that while those benefits may be ''technically guaranteed,'' if the cuts put health care providers out of business, then those guarantees will be nothing more than useless words in the Medicare Act. Guaranteed benefits are not worth much without health care providers that can treat patients, provide home health services, and run hospitals and hospice agencies. These claims are not good enough to assure seniors who have paid into the Medicare Program for all these years. It is not good enough for protecting access to health care services and the benefits that our seniors have been promised.

My colleague from New Hampshire in his amendment would back up those claims with very real enforceable mechanisms to ensure that Medicare savings are not being used to fund a whole new program at a time when the trust fund is just about broke. The Gregg amendment is needed to protect the Medicare Program. After all, if you knew the Medicare Program already had $37 trillion in unfunded obligations, would you be assured without an enforcement mechanism to back up those promises? No guarantee is worth the paper it is written on without an enforcement mechanism to back it up. That is what the Gregg amendment is all about; otherwise, it is just a meaningless guarantee that our friends on the other side of the aisle are talking about. It is not real without an enforcement mechanism.

Let me say for a third time, the Gregg amendment provides that enforcement mechanism. It makes guarantees real. It then goes much further than just the words we get from the other side of the aisle to make sure that what seniors have they will actually get when needed.

Opposition to the Gregg amendment shines light on this issue. If the Gregg amendment is not approved, it should be clear to everyone watching that all the guarantees that are made from the other side of the aisle that Medicare is protected in the Reid bill are worthless. As a result, I hope everyone will be watching carefully how the other side votes on the Gregg amendment. The Gregg amendment is essential for protecting the Medicare Program. It is essential for making guarantees real.

The way the Gregg amendment works to enforce those guarantees is quite simple. The Gregg amendment would make sure the Medicare Program is not used as a piggy bank to spend for other purposes. It would make sure the Medicare Program is not being raided to fund this new program, as the other side claims. Under this important amendment, the Director of the White House Office of Management and Budget and Medicare's Chief Actuary would both be required to add up non-Medicare savings in the bill and compare that total to the total of new spending and revenues in this bill. The Gregg amendment works then that if the non-Medicare savings don't offset all the new costs, then the Treasury Secretary and the Health and Human Services Secretary would be prohibited from implementing the new spending or revenue provisions in the bill. By doing so, the Gregg amendment would ensure that non-Medicare savings are, in fact, paying for the new spending in this bill. It would ensure at the same time that Medicare itself is not being used to pay for new spending in the bill.

It is very simple, very straightforward. It brings common sense to this whole argument that has been full of a lot of nonsense before now. The amendment, therefore, would prevent massive government expansion at the expense of Medicare beneficiaries. Massive expansion of government is one thing, if it is paid for, but it is quite another thing if you take the money out of a trust fund that is on its way to being broke and use it to set up a brandnew entitlement program to the tune of $464 billion.

As opposed to the mere nonbinding sense-of-the-Senate resolution the other side has offered to pretend to protect Medicare, this Gregg amendment requires action, action that has to be taken to protect the Medicare Program. The Gregg amendment is the enforcement mechanism for the guarantees the other side says they are making to protect Medicare. Slashing Medicare payments to start up another new and, in fact, unsustainable government entitlement program is not the way to address big and unsustainable budgets.

AMENDMENT NO. 2939

I would like to take a little bit of time to discuss the Pryor amendment. I have always been a strong supporter of transparency. In order to have a successful free market, consumers need to have information. I can't think of any reason, besides my strong objection to the underlying 2,074-page bill, to oppose the Pryor amendment. It is pretty straightforward. It requires that the Secretary of Health and Human Services have a rating system for private health plans. That sounds OK to me. An informed consumer makes better decisions. So I don't object to the Pryor amendment. But I do object to the fact that the Pryor amendment is more proof that this bill is not being crafted out in the open on the Senate floor.

The Associated Press has confirmed, based on an e-mail circulated by Democratic staff, that the Bennet amendment of last week to protect Medicare was simply ''a message amendment.''

The New York Times went on to call the Bennet amendment ''meaningless.'' Now we have a Pryor amendment that requires a level of transparency that, in fact, is already required by the bill. If you look at page 134, the bill already describes a rating system developed by the Secretary that consumers can use to choose the right health insurance plan. So if the underlying bill is already doing this, I can only assume this amendment by my friend from Arkansas is specifically designed to buy time so the White House and Democratic leadership can cut deals and twist arms behind closed doors.

That is right. The American people need to know this bill is not being written on the Senate floor. In fact, we have a 2,074-page bill before us that took since October 2, until we took it up, for one Senator, the majority leader, to put together. Somehow the other 99 Senators shouldn't have 3 weeks to look at a bill that took well over a month to put together.

Then we had the President here yesterday speaking to his caucus. That kind of obviates any efforts to get bipartisan support for this bill. I think it gives further proof that it is not only partisan but that what this final 2,074-page bill is, we don't know yet. They are trying to put together some sort of a group that can get 60 votes to get a bill passed.

Do we really know what sort of a Christmas present we are giving to the American people with this health reform bill? I don't think so.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. GREGG. Mr. President, what is the time situation?

The PRESIDING OFFICER. There is 3½ minutes for the Republicans and 1 minute 9 seconds for Democrats.

AMENDMENT NO. 2942

Mr. GREGG. Mr. President, I am not sure when the vote is going to occur. I hope sooner rather than later.

First, I congratulate the Senator from Iowa who has been involved in Medicare and the issue of how we manage Medicare for many years, both as chairman of the Finance Committee and as ranking member. His analysis of this situation relative to my amendment was absolutely dead on and accurate, as he always is. It was a breath of fresh air, common sense and plain speak in this institution, which often gets convoluted, gets tied around its own axle. In this case, it didn't. The Senator from Iowa was very precise, a Senator who used to be chairman of the Finance Committee and is now ranking.

My amendment is simple. It says the cuts in Medicare in this bill, which are

substantial—$460 billion over the first 10 years, $1 trillion over the 10 years when fully implemented, $3 trillion over 20 years, that is how much Medicare is cut—the cuts come out of primarily Medicare Advantage and provider payments, all of which will translate into a lesser quality of care for senior citizens, that those Medicare cuts cannot be used for the purpose of financing new programs which have nothing to do with seniors. The new entitlements in this bill are significant, they are expensive, and they benefit a number of people. But they don't benefit seniors. In fact, they benefit very few people who have even paid into the hospital insurance fund from which the Medicare trust fund is funded. It is totally inappropriate to take Medicare money and use it to fund a brandnew entitlement, a series of new initiatives, the biggest of which is a brandnew entitlement and the expansion of Medicaid.

The other side of the aisle—and 100 participated in the vote—sponsored an amendment, agreed to 100 to nothing, which said that wouldn't happen; that Medicare money would not be used for the purpose of funding new programs that had nothing to do with Medicare, the Bennet amendment. But that was a political vote. Everybody knew that was a statement. It was called a sense of the Senate. It didn't even raise to the standard of being an amendment. It is something around here that is a unique vehicle, the purpose of which is to make a political statement; not worth much more than the paper it is printed on.

This is different. This amendment, as the Senator from Iowa pointed out, is real. It has a hardened enforcement mechanism which requires that moneys which are saved by cutting senior citizen benefits and by cutting Medicare will not be used for the purposes of creating new programs at the Federal level.

I have heard from the other side of the aisle that this is an amendment that destroys the bill because all these new benefits they have plowed in here—there are benefits for a lot of new folks in here; there are benefits for Senators whose votes they need, and that has been publicly reported; all funded in large part by Medicare reductions or significantly by Medicare reductions—I have heard the other side of the aisle say that is going to destroy these new programs. No, it is not.

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

Mr. GREGG. I ask unanimous consent for 1 additional minute.

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

Mr. HARKIN. As long as we get an additional minute.

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

Mr. GREGG. These programs are not going to be terminated by this bill. The programs will still be in the law. They will still go forward. They just have to be paid for with something other than seniors' money, with something other than Medicare. That representation from the other side of the aisle is a straw dog.

What is not a straw dog is that my amendment enforces the language which this Congress, this Senate has already voted on 100 to nothing in the Bennet amendment. It says Medicare money will not be used to fund new programs that are not Medicare related. In the end, that means Medicare money will be used, hopefully, to the extent that these cuts go into place and these changes and benefits go into place, for seniors, to make the Medicare system more solvent because it is already headed toward insolvency.

I reserve the remainder of my time.

Mr. HARKIN. Mr. President, do I have 2 minutes?

The PRESIDING OFFICER. The Senator is correct.

The Senator from Iowa.

Mr. HARKIN. Mr. President, I listened to my colleague from Iowa earlier talking about the ''meaningless amendments'' and that amendments that do not have any teeth are just meaningless, stuff like that. I listened to that.

I want to make it very clear that the Gregg amendment is not a meaningless amendment. It has a lot of meaning because what it does is it kills health reform. Oh, yes, this is a meaningful amendment, make no mistake about it. It goes right to heart of what the health reform is all about: making sure people at the low-income end of the scale have a little bit better coverage; that is, people on Medicaid—that is section 2001—the tax credits and the copays that are in there, again, to help moderate-income people and families be able to afford better coverage for themselves and their families—he guts that too—and, of course, the expansion of SCHIP.

So really, yes, I say to my friend from Iowa, this is a meaningful amendment—if you want to kill the bill, if you want to kill it. I suppose since most of my friends on that side of the aisle would like to kill the bill, they will probably vote for the Gregg amendment. But it completely guts it—completely guts it. Why? To help protect the wasteful subsidies to the insurance companies at the expense of families who are struggling to afford insurance and seniors who rely on Medicare.

This bill lowers premiums for American families, businesses, and the country as a whole. The Congressional Budget Office just said that this week. It strengthens Medicare, it improves benefits, and it adds years of life to the Medicare trust fund.

Let's be clear. Not one dime of the Medicare trust fund is used to pay for this reform, and no guaranteed Medicare benefits will be cut. If anyone can prove otherwise, please come forward. We have had a lot of rhetoric about it, but prove that this statement is not true: Not one dime of the Medicare trust fund is used to pay for reform and no guaranteed Medicare benefits will be cut.

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

Mr. HARKIN. Mr. President, I ask unanimous consent that the Senate now proceed to vote in relation to the Pryor amendment No. 2939; and that upon disposition of that amendment, there be 2 minutes of debate prior to a vote in relation to the Gregg amendment No. 2942; that no amendments be in order to either amendment, and that the second vote in this sequence be 10 minutes in duration; that each of the above-referenced amendments be subject to an affirmative 60-vote threshold, and if the amendment achieves that threshold, then it be agreed to and the motion to reconsider be laid upon the table; that if the amendment does not achieve that threshold, then it be withdrawn; that upon disposition of the above amendments, Senator NELSON of Nebraska be recognized to call up his amendment No. 2962; that once the amendment has been reported by number, it be set aside, and the Republican leader's designee be recognized to call up his motion to commit with instructions.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Mr. President, reserving the right to object, I believe I still have 15 seconds left on my time. But independent of that, I would ask that this unanimous consent request be amended and that we agree to the Pryor amendment by unanimous consent.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Mr. President, reserving the right to object, will the Senator please repeat what he just asked?

Mr. GREGG. Mr. President, I requested that we amend the unanimous consent request and agree to the Pryor amendment by unanimous consent.

Mr. HARKIN. Mr. President, I will have to object to that. I have no instructions from Senator PRYOR. I believe he wants a vote on his amendment. So I would have to object to that.

The PRESIDING OFFICER. Objection is heard for the modification.

Mr. HARKIN. Mr. President, I want to modify my request, that the 2 minutes I asked for for debate prior to the vote be evenly divided between the two sides.

The PRESIDING OFFICER. Is there objection to the Senator's modification?

Mr. GREGG. I reserve the right to object because I would like to reserve my 15 seconds.

The PRESIDING OFFICER. Without objection, the Senator's time will be reserved, his 15 seconds will be reserved.

Is there objection to the original request of the Senator from Iowa?

Without objection, it is so ordered.

The Senator from New Hampshire has 15 seconds.

Mr. GREGG. Mr. President, I reserved the 15 seconds because it is easy to respond to the Senator from Iowa and it only takes 15 seconds.

Taking money out of the Medicare fund to fund other parts of this bill is a mistake and it is not appropriate.

The PRESIDING OFFICER. The Senator still has 3 seconds.

Mr. GREGG. I thank the Presiding Officer. I yield my 3 seconds. Actually, I yield it to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Arkansas.

AMENDMENT NO. 2939

Mr. PRYOR. Mr. President, I would like to speak on my amendment for just 1 minute.

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

Mr. PRYOR. Mr. President, I would ask my colleagues to look at this amendment very closely. It is a good consumer-oriented amendment that will allow people to make smart decisions on their health insurance. We need more of this type of information to allow the premium payers to make good decisions for themselves, for their families, and for their businesses. So I would ask my colleagues on both sides of the aisle to consider voting for this amendment.

Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to amendment No. 2939.

The clerk will call the roll.

The assistant legislative clerk called the roll.

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

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 367 Leg.]

YEAS—98

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

NOT VOTING—2

Byrd Specter

The ACTING PRESIDENT pro tempore. On this vote, the yeas are 98, the nays are zero. Under the previous order, requiring 60 votes for the adoption of amendment No. 2939, the amendment is agreed to.

Mr. BAUCUS. Madam President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2942

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be 2 minutes of debate, equally divided, prior to a vote on the amendment No. 2942, offered by the Senator from New Hampshire, Mr. GREGG.

The Senator from Montana is recognized.

Mr. BAUCUS. Madam President, the Gregg amendment is a killer amendment. It would kill the tax cuts in the bill, kill assistance for copays, kill the Medicaid expansion for the lowest income Americans, kill additional funding for the Children's Health Insurance Program.

Proponents advertise this amendment as protecting Medicare. That is false advertising. The Gregg amendment would kill health care reform. Health care reform would extend the life of the Medicare trust fund by 4 to 5 years. Health care reform would result in commonsense changes, such as decreasing hospital readmissions, decreasing hospital-acquired infections, and paying doctors and hospitals to work together. Health care reform will not reduce guaranteed Medicare benefits. Health care reform would extend the life of the Medicare trust fund.

The choice is clear. If you want to vote against tax cuts, Medicaid, and the Children's Health Insurance Program, vote for the Gregg amendment. If you want to extend the life of Medicare, vote against it.

The ACTING PRESIDENT pro tempore. The Senator from New Hampshire is recognized.

Mr. GREGG. Madam President, I appreciate—although it was with a bit of hyperbole—that the Senator from Montana has made my case.

The Medicare trust fund and its recipients will be cut by almost $½ billion in the first 10 years. That money will be taken to fund initiatives that have nothing to do with senior citizens, and it will not benefit them.

In the end, it is going to mean the Medicare trust fund is less solvent and less capable of sustaining the benefits seniors deserve. This is the only amendment we will get to vote on that absolutely guarantees the Medicare funds will not be used to fund a new entitlement or the purchase of votes for the purpose of passing this bill or to fund anything else in this bill that isn't tied to the senior citizens' benefits.

You can either vote with seniors and protect the Medicare funds for them or you can vote to raid the Medicare fund and spend it on something else.

Madam President, I ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The bill clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 56, as follows:

[Rollcall Vote No. 368 Leg.]

YEAS—43

Alexander	DeMint	McConnell
Barrasso	Ensign	Murkowski
Bayh	Enzi	Nelson (NE)
Bennett	Graham	Risch
Bond	Grassley	Roberts
Brownback	Gregg	Sessions
Bunning	Hatch	Shelby
Burr	Hutchison	Snowe
Chambliss	Inhofe	Thune
Coburn	Isakson	Vitter
Cochran	Johanns	Voinovich
Collins	Kyl	Webb
Corker	LeMieux	Wicker
Cornyn	Lugar	
Crapo	McCain	

NAYS—56

Akaka	Gillibrand	Mikulski
Baucus	Hagan	Murray
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Cantwell	Klobuchar	Schumer
Cardin	Kohl	Shaheen
Carper	Landrieu	Specter
Casey	Lautenberg	Stabenow
Conrad	Leahy	Tester
Dodd	Levin	Udall (CO)
Dorgan	Lieberman	Udall (NM)
Durbin	Lincoln	Warner
Feingold	McCaskill	Whitehouse
Feinstein	Menendez	Wyden
Franken	Merkley	

NOT VOTING—1

Byrd

The ACTING PRESIDENT pro tempore. On this vote, the yeas are 43, the nays are 56. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is withdrawn.

Mr. NELSON of Nebraska. 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. NELSON of Nebraska. Madam 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.

AMENDMENT NO. 2962 TO AMENDMENT NO. 2786

Mr. NELSON of Nebraska. Madam President, I call up amendment No. 2962.

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

The legislative clerk read as follows:

The Senator from Nebraska [Mr. NELSON], for himself, Mr. HATCH, Mr. CASEY, Mr. BROWNBACK, Mr. THUNE, Mr. ENZI, Mr. COBURN, Mr. JOHANNS, Mr. VITTER, and Mr. BARRASSO, proposes an amendment numbered 2962 to amendment No. 2786.

Mr. NELSON of Nebraska. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To prohibit the use of Federal funds for abortions)

Beginning on page 116, strike line 15 and all that follows through line 15 on page 123, and insert the following:

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), nothing in this Act (or any amendment made by this Act) shall be construed to require any health plan to provide coverage of abortion services or to allow the Secretary or any other person or entity implementing this Act (or amendment) to require coverage of such services.

(2) COMMUNITY HEALTH INSURANCE OPTION.—The Secretary may not provide coverage of abortion services in the community health insurance option established under section 1323, except in the case where use of funds authorized or appropriated by this Act is permitted for such services under subsection (b)(1).

(3) NO DISCRIMINATION ON THE BASIS OF PROVISION OF ABORTION.—No Exchange participating health benefits plan may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(b) LIMITATION ON ABORTION FUNDING.—

(1) IN GENERAL.—No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

(2) OPTION TO PURCHASE SEPARATE SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall be construed as prohibiting any non-Federal entity (including an individual or a State or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act; and

(B) such coverage or plan is not purchased using—

(i) individual premium payments required for a qualified health plan offered through the Exchange towards which a credit is applied under section 36B of the Internal Revenue Code of 1986; or

(ii) other non-Federal funds required to receive a Federal payment, including a State's or locality's contribution of Medicaid matching funds.

(3) OPTION TO OFFER SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall restrict any non-Federal health insurance issuer offering a qualified health plan from offering separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated by this Act;

(B) administrative costs and all services offered through such supplemental coverage or plan are paid for using only premiums collected for such coverage or plan; and

(C) any such non-Federal health insurance issuer that offers a qualified health plan through the Exchange that includes coverage for abortions for which funding is prohibited under this subsection also offers a qualified health plan through the Exchange that is identical in every respect except that it does not cover abortions for which funding is prohibited under this subsection.

Mrs. BOXER. Madam President, would my friend yield for a unanimous consent request?

Mr. NELSON of Nebraska. Yes.

The ACTING PRESIDENT pro tempore. The Senator from California.

Mrs. BOXER. Madam President, we are trying to get the times locked in so that Senators who have come over here get their time. So I ask unanimous consent that Senator NELSON speak for 10 minutes, BOXER for 5, MIKULSKI for 10, GRASSLEY for 10, CORNYN for 10, GILLIBRAND for 10, and then Senator MCCAIN wishes to comment.

Mr. MCCAIN. I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

The Senator from Nebraska.

Mr. NELSON of Nebraska. Madam President, my lead cosponsor, Senator HATCH, will appear sometime later and speak in favor of amendment 2962. He is unable to be here at the moment.

Before the Thanksgiving break, I voted with a number—and the majority, actually—of my colleagues in favor of beginning this debate. Debate is essential in our democracy. It keeps our country resilient and strong through changing times.

Before that vote, some argued here on the Senate floor that we shouldn't hold this open and full debate. They seemed to suggest that obstruction was better than action. Some also argued here on the floor that the November 21 vote was about abortion. They were wrong. That vote was whether to begin a debate on an issue that has consumed the American public. Now is the time to start debating the issue of abortion, as we are addressing many other issues in health care reform.

I wish to discuss the amendment that I propose, along with a bipartisan group of colleagues, which includes Senators HATCH, CASEY, BROWNBACK, THUNE, COBURN, JOHANNS, VITTER, and BARRASSO. The amendment we offer today mirrors the Stupak language added to the House health care bill.

For more than three decades, taxpayer money has not been used for elective abortions, and it shouldn't under any new health reform legislation either. Some suggest that the Stupak language imposes new restrictions on abortion. I disagree. We are seeking to justify the same standards on abortion to the Senate health care bill that already exist for Federal health programs. They include those covering veterans, all Federal employees, Native Americans, active-duty servicemembers, and others.

I note that the Senate health care bill, if enacted, would indeed chart new ground—it covers abortion. The language in the bill goes around the Federal standard disallowing public funding of abortion. A clear majority of Americans, including my constituents in Nebraska, support this prohibition against using public money to cover abortion. Our amendment formally extends that standard to this health reform bill.

The U.S. Supreme Court has held that government may regulate abortion and may disallow public funds being used for elective abortions. Beginning in 1976, with the Hyde amendment, Congress has prohibited public funding for elective abortion in all significant health-related bills. Exceptions have been preserved for when the life of the mother is in danger or in cases of rape or incest. And except for those exceptions, public funds may not be used for any health care benefits package that covers abortion.

Some have now cited the Federal Employees Health Benefits Program—FEHBP—as a possible model for health care reform. The FEHBP helps pay premiums for many different private health insurance plans. That way, Federal employees may choose the insurance plan that best suits their budget and personal needs. It is important to note that none of the benefits packages offered to Federal employees provide health insurance coverage for abortion. I repeat: None of the benefits packages offered to Federal employees provide coverage for abortion, nor do benefits packages that are offered to individuals in other Federal programs, such as the Children's Health Insurance Program, Medicare, Medicaid, Indian Health Services, veterans health, and military health care programs.

Some have argued that the Stupak language imposes tougher restrictions than in current law. That is not the case. Our amendment merely aims to extend the current standard to this new legislation.

On another point, under Federal law, States are allowed to set their own policies concerning abortion. Many States oppose the use of public funds for abortion. Many States also have passed laws that regulate abortion by requiring informed consent and waiting periods, requiring parental involvement in cases where minors seek abortions and protecting the rights of health care providers who refuse, as a

matter of conscience, to assist in abortions. And perhaps most importantly, there is no Federal law, nor is there any State law, that requires a private health plan include abortion coverage.

I believe the current health care reform we are debating should not be used to open a new avenue for public funding of abortion. We should preserve the current policies prohibiting the use of taxpayer money for abortion that have existed for more than three decades.

A number of polls this year have again shown that most Americans do not support using taxpayer money for abortion. The Senate bill, as proposed, goes against that majority public opinion. The bill says the Secretary of Health and Human Services may allow elective abortion coverage in the Community Health Insurance Option—the public option—if the Secretary believes there is sufficient segregation of funds to ensure Federal tax credits are not used to purchase that portion of the coverage.

The bill would also require that at least one insurance plan cover abortion and one that does not cover abortion be offered on every State insurance exchange. Federal legislation establishing a public option that provides abortion coverage and Federal legislation allowing States to opt out of the public option that provides abortion coverage eases the restrictions established by the Hyde amendment.

Our amendment would prohibit Federal funds from being used for elective abortion services in the public option and also prohibit individuals who receive tax credits from purchasing a plan that provides elective abortions.

I have always been pro-life and I have a strong record opposing abortion. As Governor of Nebraska in the 1990s, I signed into law the parental notification law and the ban against partial birth abortion. In the Senate, I cosponsored and voted for legislation that prohibits taking minors across State lines to avoid parental notification laws and voted for legislation creating a separate offense for harming or killing an unborn child in utero during the commission of specified violent crimes.

Aside from my personal views, however, I think most Americans would prefer that the health care reform we are working on remain neutral on abortion. Public polls suggest so. So does the fact that over the last 30-plus years Congress has passed new Federal laws that have not provided public funding for abortions.

So the question has been settled: Most Americans, even some who support abortion, do not want taxpayer money to be used for abortions. We should not break with precedent on this bill.

And, finally, as President Obama has said, this is a health care reform bill. It is not an abortion bill. It is time to simply extend the standard disallowing public funding of abortion, which has stood the test of time, to new proposed Federal legislation.

I look forward to debating this and other issues in the health reform bill as we work to address solutions to our troubled health care system. Today it costs too much and delivers too little to the people of my State and to most Americans.

Madam President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Texas.

Mr. CORNYN. Madam President, this last Thursday was one of those days in Washington where the left hand of government didn't know what the right hand was doing. On one end of Pennsylvania Avenue, the President was hosting a jobs summit. But here on the other end of Pennsylvania Avenue, we continued debate on a health care bill which will, for reasons I will explain, be a job killer and will discourage small and large businesses from hiring new people, even though unemployment exceeds double digits.

The November jobs number shows the economy is still hurting. Not only is the unemployment rate at 10 percent, 11,000 more families have lost a breadwinner. More than 15 million Americans remain unemployed, and more than 3 million Americans have lost their jobs since Congress passed the stimulus bill in February, which failed in its essential purpose—to keep unemployment under 8 percent.

According to an article by Mort Zuckerman in U.S. News and World Report, 21 percent of all families have an immediate family member who has lost a job. My family is one of those. My daughter has lost a job. And, according to the article, 33 percent—a third—of U.S. families have an immediate family member or a close friend who has lost a job. But the President, during the jobs summit, seemed to be completely unaware of the impact that policies here in Washington have on the desire and willingness of job creators to actually re-hire laid-off American workers. He seemed to be oblivious to the role of the private sector in creating those jobs.

If you look at the States that have been most successful in creating jobs, it is clear that jobs-friendly policies can actually lead to better results. I don't want to brag, but Texas has been one of the best economies we have had, even during this tough recession. Many analysts have wondered why that is—from the Wall Street Journal to The Economist. But it is clear to me that the Texas economy has been doing better than other States because our laboratory of democracy has embraced better policies—things such as growing jobs in the private sector over government, lower taxes, fiscal discipline, right-to-work legislation, and commonsense civil justice reforms, to mention a few.

But my State isn't the only State that has been successful in embracing these sound job-creating policies. Other States have adopted similar policies and they have seen similar results. That is why it is so frustrating to many of us to see the White House ignore these results and focus on policies that will actually kill jobs, not encourage job creation.

For example, cap and trade. In Texas alone, according to the State comptroller, more than 300,000 jobs would be lost in the State of Texas if we embrace the ill-considered and misguided cap-and-trade legislation that has passed the House and which we will consider later—perhaps next year. Here is a quote from economist Anne Layne-Farrar regarding card check—eliminating the secret ballot:

> For every 3 percentage points gained in union membership through card checks and mandatory arbitration, the following year's unemployment rate is predicted to increase by 1 percentage point—and job creation predicted to fall by about 1.5 million jobs.

So cap and trade is a job killer and card check is a job killer. Then there are higher taxes. Small businesses, which are America's best job creators, may soon face the highest marginal tax rate in a quarter of a century. And still the White House wants to raise taxes higher on energy producers right here at home as well as companies that sell American products in foreign markets. The biggest job killer of all, of course, is the bill that is presently on the Senate floor. This is a $2.5 trillion expansion of government, and it will cost Americans jobs in a number of ways.

We will recall the President's pledge on September 12, 2008. He said:

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

But yesterday the Joint Tax Committee came out with a new score or analysis of what the impact would be of the Reid health care bill. They said the Reid health care bill increases taxes for 25 percent of taxpayers earning less than $200,000. That is even after the subsidies that are provided for in this bill are applied. Without those subsidies about 42 percent of taxpayers would see an increase in their taxes.

There are nearly $½ trillion of higher taxes in this bill, including things such as $149 billion in excise taxes on Americans who have certain types of health plans, a $15.2 billion tax on all taxpayers with catastrophic medical costs, and $14.6 billion of additional taxes on workers who use FSAs.

There are also taxes that allegedly target only the rich. But you know what. These taxes hit thousands of small businesses. That is right; the very job creators we are trying to encourage to create new jobs and retain new jobs, particularly those who file as sole proprietors or partnerships or subchapter S corporations that pay flowthrough income on individual tax returns at individual rates.

For example, a $54 billion increase in the Medicare payroll tax would be used not to pay for Medicare but to pay for yet a new entitlement spending program. The Reid bill also adds $100 billion in new taxes and fees on the health

care industry which will, of course, be passed down to consumers, which is one reason insurance premiums are calculated to go up under this bill, not down.

The Reid bill would create new punitive taxes on businesses that do not offer a Washington-approved health care plan.

Then there is the employer mandate. The employer mandate will kill jobs because the additional cost of insurance will be passed along to workers in the form of lower wages or result in reduced hours or layoffs. Harvard Professor Kate Baicker said this:

> Workers who would lose their jobs are disproportionately likely to be high school dropouts, minority and female. . . . Thus, among the uninsured, those with the least education face the highest risk of losing jobs under employer mandates.

I mentioned the Reid bill would raise premiums for small businesses. Under one study those premiums in the group market would rise by 20 percent. I thought the purpose of health care reform was to lower and make more affordable health care, not to make it more expensive. But the Reid bill does the opposite of reform and makes it worse, not better.

Then, of course, the Reid bill would kill jobs by increasing the cost shifting due to low Medicaid reimbursements. Of course, cost shifting occurs because Medicaid pays a fraction of what private insurance pays. Medicare pays about 80 percent, and so in order to make up the difference, those with private health insurance have to pay an additional cost in the form of cost shifting. Fifteen million more Americans on Medicaid would make this worse, not better.

The Reid bill would kill jobs by raising State and local taxes because of unfunded mandates. Because of the expansion of Medicaid, which is not paid for by the Federal Government, over 10 years the State of Texas alone would see $20 billion more in Medicaid spending because of this unfunded mandate—$20 billion. We are a big State, but we can't afford $20 billion more in an unfunded mandate because of the Medicare expansion under this bill.

It should not be any surprise that the Reid bill and these other job-killing policies are the reasons the private sector is not hiring. Again, according to Mort Zuckerman of U.S. News and World Report, businesses ''are holding back in hiring because of anxiety over the administration's policies on such matters as increased health care costs . . . higher taxes . . . more corporate regulations . . . and disaffecting labor policies.''

These policies are causing the greatest anxiety among small business owners. Firms with fewer than 20 workers employ a quarter of the workforce. In the last economic expansion they accounted for 4 out of 10 new jobs.

I hear this from my constituents in Texas, people such as Richard Belden who owns a small retail grocery business that has been in the family for 54 years and employs 75 people. He files as a subchapter S corporation, so he pays taxes according to the highest marginal tax bracket. He is going to get hit by these taxes.

Do you think that is going to make it easier for him to hire more people and keep the people he has or make it harder? I think the answer is self-evident.

This is from Nathan Avard, who owns and operates five Burger King restaurants in northeast Texas and employs more than 100 people. He said the employer mandate included in this bill will make it harder, not easier, for him to keep the employees he has. He believes the employer mandate would cost him thousands of dollars per restaurant, effectively eliminating much of his profit and making it exceedingly difficult for him to operate and improve his business in this economy.

I have heard the same story from the Chamber of Commerce in Lubbock, TX, that represents more than 2,100 businesses that employ more than 57,000 workers. But it is not just the Lubbock, TX, Chamber, but the Greater Irving-Los Colinas Chamber, the Greater Austin Chamber, the Rosenberg-Richmond Area Chamber, the Harlingen Area Chamber, the Liberty-Dayton area Chamber, the Tyler Area Chamber, the Bryan/College Station's Chamber, the Port Aransas Chamber, the Northwest Houston Chamber, the Odessa Chamber, the Deer Park Chamber, the Henderson Area Chamber, the West I–10 Chamber, the Crowley Area Chamber, Marble Falls/Lake LBJ Chamber, Granbury Chamber, McAllen Area Chamber, and the Washington County Chamber. You get the idea. These are job-killing policies, and this bill is perhaps the biggest of them all.

Of course, a few enterprises will get bigger under the Reid bill; namely, the Internal Revenue Service. According to the nonpartisan Congressional Budget Office, the IRS will need a budget nearly twice its current size to enforce the Reid bill. The IRS will need more agents and more bureaucrats to collect the new taxes, enforce all of the new mandates, and apply all the additional redtape.

I think we should be about facilitating the creation of new jobs not killing jobs through ill-considered policies such as this bill.

I yield the floor.

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

Mrs. BOXER. Madam President, it is an honor to be here in the Senate at a time when we are working on one of the major issues of our time. We know that generations of leaders in both parties have tried to solve the health care crisis, and they have done it bit by bit. We read history. We know that leaders struggled with Social Security. The Democrats were in the forefront. Republicans fought us every step of the way. Franklin Roosevelt took the lead on that, and we had John Kennedy and Lyndon Johnson take the lead on Medicare. The Republicans fought us every inch of the way. We had some cooperation from certain Senators and certain Members of Congress, but overall it was very difficult.

This fight is very difficult to make sure that we turn things around. We live in a society where, if we do not step into the breach—we are told by nonpartisan surveys that if we do nothing—and this is important—average premiums for our families in California will be 41 percent of income. In States such as Pennsylvania it will be 50 percent of income. We know what that means. People will not have health insurance. So we can pull the covers over our heads and say it is too hard; it is too tough. We can turn our backs on the fact that 62 percent of bankruptcies are related to a health care crisis. We could turn our backs on that. We could turn our backs on the fact that the infant mortality rate in America is 29th out of 30 nations—that is where we come out.

This is America, the greatest country in the world. Something is wrong when so many people do not have access to insurance; and even if they do, when they need it most it is gone.

How proud am I to be here at this time? Very proud. How grateful am I to the people of my State for sending me back here three times, so I can stand here and be a voice for them? I can't tell you how proud I am.

When we started this health care debate we knew it was important to the people we represent and we knew it was important to the economy of this country. Senator CORNYN has gotten up and said this bill is terrible for the economy. Let me tell you, there are $27 billion of tax cuts in this bill. Let me repeat that—$27 billion of tax cuts for small business.

There are billions of dollars of tax breaks for individuals. For people to stand up and say this is not good for our economy, I don't think they understand or get it. If we continue with the status quo, that is when we are in trouble.

The women of the Senate have been very involved, the Democratic women. We have worked together to make sure this bill meets the needs of all of our families, including the women of this country. Senator MIKULSKI, who is on the floor, took the lead and made sure that we corrected a problem that was in the bill, a problem which basically was unclear as to who was going to set the benefits. We wanted to make sure that women could get mammograms after 40 every year. Senator MIKULSKI fixed it by making sure the head of Health and Human Services is going to be the one to decide what is covered.

Women's prevention has now gone way up to the top of the list because of Senator MIKULSKI and the women who worked with her. We are very proud of that.

There is one thing that was taken care of in the Reid bill that we didn't

think we would have an argument about; that is, we thought we had an understanding that we were not going to bring up the issue of abortion; that it was not necessary to do it because we were not doing anything in the bill—Senator REID doesn't do anything in the bill that changes the current agreement.

Let me say, because I started in the House in the 1980s, I was part of that agreement. I offered the amendment that said, yes; it is true no Federal funds could be used unless the life of the woman was at stake, for abortion. Through my amendment we added rape and incest. Those are the only three exceptions. No Federal funds could be used for abortion except to save the life of the woman or if she is a victim of rape or incest. That agreement has held for three decades.

It is fair to say neither side is thrilled with it, but the fact is, the agreement has held. The fact is, Senator REID has crafted a bill, which is the underlying bill, that preserves that three-decades-long agreement.

But over on the House side they passed the radical Stupak amendment which strikes at the heart of this delicate compromise by preventing women from using their own private funds for their legal reproductive health care. That is a big shock because women have been able to utilize their own private funds in order to get a legal procedure—legal procedure—and never has anyone, to my knowledge, on either side of the aisle said she could not get access to insurance to cover the whole range of legal reproductive health care if she uses her own funds. This amendment takes us way back.

Here is what is interesting. The people who bring us this—mostly it is going to be the men who speak on this, I think. We will see if that is right or wrong, but I predict that.

The men who have brought us this do not single out a procedure that is used by a man, or a drug that is used by a man, that involves his reproductive health care and say they have to get a special rider. There is nothing in this amendment that says if a man someday wants to buy Viagra, for example, that his pharmaceutical coverage cannot cover it; that he has to buy a rider. I would not support that. And they should not support going after a woman, using her own private funds, for her reproductive health care.

Is it fair to say to a man: You are going to have to buy a rider to buy Viagra—and this is public information. It could be accessed. No, I don't support that. I support a man's privacy just as I support a woman's privacy.

So it is very clear to me that this amendment would be the biggest rollback of a woman's right to choose in decades.

We didn't ask for this fight. We didn't plan for this fight. We don't want this fight. We simply want to ensure that this three-decades-long agreement is kept in place. And that is what Senator REID does in the underlying bill. It is very clear that in the underlying bill, there is a firewall between Federal funds and private funds. All we are saying is, please leave it alone. We believe it is discriminatory to single out a procedure only women can utilize and say to the women of this Nation: Yes, this is a legal procedure, but you can't use your own private funds. Senator REID is very clear. He puts a firewall in place between the Federal funds and the private funds.

Roe v. Wade is still the law of the land. I know a lot of my colleagues would like to see it overturned. They would like to make abortion illegal at the earliest stages. They would like to criminalize it. They would like to put women and doctors in jail. The fact is, Roe v. Wade is the law of the land. At the early stages of a pregnancy, a woman has a right to choose. That is the law. Later on, she can't do it. There are restrictions for her, hurdles for her. That is what Roe does.

There are many people, particularly on the other side of the aisle—more than on our side, for sure—who want to overturn Roe. They know they can't do it because the vast majority of the people support a woman's right to choose at the early stages of a pregnancy. So what can they do? They can make it impossible for her to access a doctor for this procedure. In this bill, they go after her insurance. It is surprising to me that such an amendment could pass the House, but it did.

I am asking my colleagues, women and men, both sides of the aisle, to please stand up for equality. Please don't single out women. What have women done to deserve this? They are our mothers, our daughters, our grandmas. They serve in the military with dignity. Why punish them this way? Why have such a lack of respect for them that they can't even get reproductive health care with their own private funds? It is, to me, such a rollback of women's rights.

I believe we will defeat this in the Senate. I believe Senator REID deserves a lot of credit because what he did in the underlying bill is preserve the status quo—no Federal funds for abortion, not a dollar, but a woman can use her own private funds to buy health insurance.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

MOTION TO COMMIT

Mr. MCCAIN. Madam President, as is the agreed-upon procedure by the two leaders, I send a motion to commit to the desk with instructions, as part of the side-by-side procedure that has been agreed to by the majority leader and the minority leader, and ask for its consideration.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from Arizona [Mr. MCCAIN] moves to commit the bill (H.R. 3590) to the Committee on Finance with instructions.

Mr. MCCAIN. I ask unanimous consent that reading of the motion be dispensed with.

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

The motion is as follows: Motion to commit the bill H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that include applying the amendments made by section 3201(g) (related to Grandfathering Supplemental Benefits for Current Enrollees) to all individuals enrolled in a Medicare Advantage plan under part C of title XVIII of the Social Security Act as of the date of enactment, in order to ensure the following:

That the 10,600,000 seniors enrolled in Medicare Advantage can continue to keep the benefits they have and may continue to benefit from the protection against traditional Medicare's significant out-of-pocket costs, wellness programs, and vision, hearing, and dental benefits that they have come to rely on.

That the Senate does not cut benefits in a program that disproportionately benefits low-income and minority seniors by providing protection from higher out-of-pocket spending.

That the approximately $5,000,000,000 ''Grandfathering'' protections under the amendments made by section 3201(g), which provide Medicare Advantage enrollees in certain States, including Florida, protection from a 64 percent cut in benefits under the Medicare Advantage program under part C, are also provided to the following:

The 181,304 Medicare Advantage enrollees in Alabama.

The 462 Medicare Advantage enrollees in Alaska.

The 329,157 Medicare Advantage enrollees in Arizona.

The 70,137 Medicare Advantage enrollees in Arkansas

The 1,606,193 Medicare Advantage enrollees in California.

The 198,521 Medicare Advantage enrollees in Colorado.

The 94,181 Medicare Advantage enrollees in Connecticut.

The 6,661 Medicare Advantage enrollees in Delaware.

The 7,976 Medicare Advantage enrollees in the District of Columbia.

The 946,836 Medicare Advantage enrollees in Florida.

The 176,090 Medicare Advantage enrollees in Georgia.

The 79,386 Medicare Advantage enrollees in Hawaii.

The 60,676 Medicare Advantage enrollees in Idaho.

The 176,395 Medicare Advantage enrollees in Illinois.

The 148,174 Medicare Advantage enrollees in Indiana.

The 63,902 Medicare Advantage enrollees in Iowa.

The 43,867 Medicare Advantage enrollees in Kansas.

The 110,814 Medicare Advantage enrollees in Kentucky.

The 151,954 Medicare Advantage enrollees in Louisiana.

The 26,984 Medicare Advantage enrollees in Maine.

The 56,812 Medicare Advantage enrollees in Maryland.

The 199,727 Medicare Advantage enrollees in Massachusetts.

The 406,124 Medicare Advantage enrollees in Michigan.

The 284,101 Medicare Advantage enrollees in Minnesota.

The 44,772 Medicare Advantage enrollees in Mississippi.

The 195,036 Medicare Advantage enrollees in Missouri.
The 27,592 Medicare Advantage enrollees in Montana.
The 30,571 Medicare Advantage enrollees in Nebraska.
The 104,043 Medicare Advantage enrollees in Nevada.
The 13,200 Medicare Advantage enrollees in New Hampshire.
The 156,607 Medicare Advantage enrollees in New Jersey.
The 73,567 Medicare Advantage enrollees in New Mexico.
The 853,387 Medicare Advantage enrollees in New York.
The 251,738 Medicare Advantage enrollees in North Carolina.
The 7,633 Medicare Advantage enrollees in North Dakota.
The 499,819 Medicare Advantage enrollees in Ohio.
The 84,980 Medicare Advantage enrollees in Oklahoma.
The 249,993 Medicare Advantage enrollees in Oregon.
The 864,040 Medicare Advantage enrollees in Pennsylvania.
The 400,991 Medicare Advantage enrollees in Puerto Rico.
The 65,108 Medicare Advantage enrollees in Rhode Island.
The 110,949 Medicare Advantage enrollees in South Carolina.
The 8,973 Medicare Advantage enrollees in South Dakota.
The 233,024 Medicare Advantage enrollees in Tennessee.
The 532,242 Medicare Advantage enrollees in Texas.
The 85,585 Medicare Advantage enrollees in Utah.
The 3,966 Medicare Advantage enrollees in Vermont.
The 151,942 Medicare Advantage enrollees in Virginia.
The 225,918 Medicare Advantage enrollees in Washington.
The 88,027 Medicare Advantage enrollees in West Virginia.
The 243,443 Medicare Advantage enrollees in Wisconsin.
The 3,942 Medicare Advantage enrollees in Wyoming.

Mr. MCCAIN. Madam President, the motion I am offering would simply commit the bill back to the Finance Committee for a short period to apply the same grandfathering provision in this legislation to all Medicare Advantage beneficiaries, the provision in the bill as it is specifically drafted, to prevent the drastic Medicare Advantage cuts from impacting some seniors in Florida, which compare to the cuts facing Medicare Advantage enrollees in the rest of Florida and the rest of America, including the 330,000 Medicare Advantage enrollees in my State.

Basically, this motion says that the same benefits that have been granted in the legislation to citizens in Florida would also apply to citizens who are enrollees in the Medicare Advantage Program all over America. It is pretty simple.

Specifically, starting in 2012, this motion would accomplish a fix that allows all Medicare Advantage enrollees to maintain the current levels of benefits on the date of enactment. That would be in keeping with the sense-of-the-Senate resolution that was agreed to by the Senator from Colorado, Mr. BENNET, that called for all Americans to be able to keep the same level of benefits as they presently have today under Medicare and Medicaid.

During the Finance Committee markup, the senior Senator from Florida advocated in favor of treating certain Medicare Advantage enrollees in Florida better than the rest of America's seniors under Medicare Advantage.

Let me read from two articles written at the time of the Senate Finance Committee's deliberation. From the New York Times, ''Senator Tries to Allay Fears on Health Overhaul,'' September 24, 2009:

But Mr. Nelson, a Democrat, has a big problem. The bill taken up this week by the committee would cut Medicare payments to insurance companies that care for more than 10 million older Americans, including nearly one million in Florida. The program, known as Medicare Advantage, is popular because it offers extra benefits, including vision and dental care and even, in some cases, membership in health clubs or fitness centers.

''It would be intolerable to ask senior citizens to give up substantial health benefits they are enjoying under Medicare,'' said Mr. Nelson, who has been deluged with calls and complaints from constituents. ''I am offering an amendment to shield seniors from those benefit cuts.''

Pretty simple. The Senator from Florida believes there would be cuts to the Medicare Advantage Program, and he was able to get into this bill an exemption for some 950,000 enrollees in Medicare Advantage in Florida. Admirably, the Senator from Florida was able to insert in this bill protection for 800-some or 900-some thousand constituents of his who are Medicare enrollees. There are 330,000 of them in my State who are seniors, who have paid into Medicare, who have the Medicare Advantage Program which, under the legislation, with the exception of the carve-out for the citizens in Florida by Mr. NELSON, would also then lose their benefits.

Similar concerns exploded into public view on Wednesday as members of the Finance Committee slogged through a mammoth health care overhaul bill for a second day.

Senator Nelson said Republicans were waging a ''scare campaign,'' but he shares some of their concerns. His predicament highlights the political risks for Democrats eager to reassure older Americans who vote in large numbers.

There are risks for President Obama as well. He cannot afford to lose Mr. Nelson's vote. White House officials have offered to work with him to address his concerns. Mr. Obama has said repeatedly that ''if you like your health care plan, you will be able to keep it.''

That is one of the remarkable statements that is obviously contradicted by anybody who reads this bill. Any one of 11 million Americans, with the exception of Senator NELSON's constituents, who are under Medicare Advantage will see cuts in Medicare Advantage. That is a fact. If those 11 million Americans like their health care plan, they will not be able to keep it.

The cost of Mr. Nelson's proposed fix—to preserve benefits for many people enrolled in the private Medicare plans—could total $40 billion over 10 years, and that could also be a problem for the White House. Mr. Obama has promised not to sign a health bill that increases the deficit, and so far Mr. Nelson has not said precisely how he would pay for his amendment.

Approval of the amendment could invite other Democrats to ask for similar deals that might make the bill more palatable to their constituents, but more costly as well.

Well, since that September article, obviously other Senators have asked for the same shielding of their constituents who are enrolled in Medicare Advantage.

An October 20, 2009, Bloomberg story, ''Reid Leads Democrats into Carving Out Favors for States on Health.''

Democrats such as Senator Bill Nelson of Florida and Ron Wyden of Oregon secured provisions setting aside $5 billion to shore up benefits for constituents who participate in Medicare Advantage. That program allows private insurers to contract with the government to provide Medicare benefits. Nelson said the aid isn't directed solely at Florida. ''It affects several States, including New York,'' he said. ''We're trying to grandfather in seniors so they don't lose the benefits they have.''

Well, I am trying to carry out Senator NELSON's ambition. Senator NELSON said that, in effect, several States, including New York, are trying to grandfather in seniors so they don't lose the benefits they have. That is exactly what this motion is all about.

I assume I can expect Senator NELSON's affirmative vote, along with all others listed in the motion of the 11 million people who are under Medicare Advantage in their States.

And the deal-making continues. We have now learned about the special provisions in the 2,000-page legislation designed for certain Senators—I might add, at the expense of Medicare Advantage members in other States and the American taxpayer. We have had to read about such deals because they have been cut in secret closed meetings without the benefit of the C–SPAN cameras, as promised. Just the other day, it came to light that this legislation has special provisions for Oregon, New York, and a special one in Florida. I have had a conversation with Senator WYDEN of Oregon, and he says that is not the case. I will certainly take Senator WYDEN's word for it.

I want the same protections extended to all seniors. That is all this motion is about—the same protection for all seniors, no special deals for any constituents related to the State in which they reside or the influence of their elected representatives. That is not the way we should treat seniors who have paid into Medicare Advantage.

The special carve-out for some Florida seniors is quite interesting. Despite beneficiaries in Florida hearing the President's promises about being able to keep what you have, it appears the 950,000 Medicare Advantage enrollees in Florida aren't satisfied with the Democrats' promises to protect so-called guaranteed benefits. Medicare Advantage beneficiaries in Florida thought

they would be able to keep the Medicare Advantage benefits that provide protection from high cost sharing in traditional Medicare, wellness programs, and vision, hearing, and dental benefits upon which they have come to rely.

However, when Florida beneficiaries learned they were not going to be able to keep what they have—in fact, they were going to see a 64-percent cut in benefits—a deal benefiting some at the expense of other Medicare Advantage beneficiaries and taxpayers was added in exchange for support to move forward on the cuts.

Let me point out, despite attempting to protect hundreds of thousands of Florida seniors from benefit cuts, Senator NELSON's deal still leaves approximately 150,000 Florida seniors and seniors across the country unprotected. So even in the proposed deal that was cut, Senator NELSON was willing to leave 150,000 beneficiaries subject to Medicare Advantage cuts.

The Medicare Advantage Program is a program that had bipartisan support and the support of 11 million seniors who are enrolled in the program.

Just a few short years ago, when Congress enacted the Medicare Modernization Act, new funding was intentionally provided to stabilize the Medicare health plan program. This was one of the few issues on which there was strong bipartisan agreement during the 2003 Medicare debate. It was done to ensure seniors all across America had access to an option in the Medicare Program, an option for additional, better benefits than are available under the traditional Medicare Program.

In June 2003, several of our colleagues, including Senator SCHUMER and Senator KERRY, offered a bipartisan amendment on the Senate floor to provide additional funding for benefits under the Medicare Advantage Program. So I find it a little interesting that Members on the other side want to cut benefits to seniors now. Even though they supported the funding before, they now want to cut them.

Later in 2003, as the Medicare conference committee was completing its deliberations, a bipartisan group of 18 Senators signed a letter urging the conferees to provide a meaningful increase in Medicare Advantage funding. This letter was signed by a diverse group of our colleagues, including Democratic Senators such as DIANNE FEINSTEIN, CHRISTOPHER DODD, RON WYDEN, FRANK LAUTENBERG, PATTY MURRAY, ARLEN SPECTER, MARY LANDRIEU, and MARIA CANTWELL.

Here is a letter dated September 30, 2003. It says ''United States Senate,'' and it is signed by a number of Senators, including my colleague, Senator KERRY. It says:

Dear Medicare conferee:

We are writing to ask you, as a member of the Medicare conference committee, to ensure that the final Medicare bill includes a meaningful increase in Medicare+Choice funding in fiscal years 2004 and 2005.

So I guess my friend and colleague, Senator KERRY, was against cuts in funding before he was for them. He was against them before he was for them. So anyway it goes on to say:

We strongly support additional Medicare+Choice funding for two very important reasons: (1) to protect the health care choices and benefits of the nearly 5 million Medicare beneficiaries who are currently enrolled in private sector health plans; and (2) to strengthen the foundation for future health plan choices.

We believe that the Medicare+Choice funding provisions . . . are critically important to preserving choice and quality for America's seniors. We urge you to include these provisions in the final bill reported out of the Medicare conference committee.

Since then the Medicare Advantage Program has been popular enough so that 11 million of our senior citizens have joined the program. I think that is a pretty impressive number of people who have decided to join the program. So I urge my colleagues to vote for this motion, just to give equal access to a very popular program to all citizens rather than just give it to several hundred thousand who happen to live in a certain part of the country.

Mrs. BOXER. Madam President, will the Senator yield for just a brief question on time, I say to Senator MCCAIN?

I just wondered how much longer the Senator was going to go because we have people waiting on both sides to speak up to 10 minutes.

Mr. MCCAIN. I am not sure.

So, Madam President, recently there was an article in the North County Times from San Diego, dated Saturday, December 5, 2009.

I would say to the Senator from California, in response to her question, this is a very important issue, as the Senator from California just pointed out. I have a lot to say on it, and I have waited my turn to speak. In keeping with the procedures that are in keeping with the agreement between the two leaders, I do not expect to be too much longer, but I do not expect to curtail my remarks on this very important issue at 5:20 p.m. in the afternoon.

So here is an article from the North County Times from San Diego, dated December 5, 2009: ''REGION: State ends subsidy for mammograms to low-income women under 50.'' I repeat: ''State ends subsidy for mammograms to low-income women under 50.'' It goes on to say:

The eligibility age for state-subsidized breast cancer screening has been raised from 40 to 50 by the California Health and Human Services Agency, which will also temporarily stop enrollment in the breast cancer screening program.

Advocates for low-income women, whose health care the department helps pay for, say the cuts put a two-tier system in place that is based on money rather than medical standards.

The cuts will greatly harm the clinic's mammogram program, said Natasha Riley, manager of Vista Community Clinic's Breast Health Outreach and Education Program.

The clinic and others like it in San Diego County provide reduced-cost care, mostly to low-income people, with money from the state and some private donations.

''More than 50 percent of the women we give breast exams and mammograms to are in their 40s,'' Riley said. ''The majority of our current breast cancer survivors are women in their 40s.''

The state's decision, announced Dec. 1 and effective Jan. 1, follows a controversial federal recommendation last month that mammograms before the age of 50 are generally not needed.

So now we see the Federal recommendation that was made last month—that mammograms before the age of 50 are generally not needed—is now being implemented in the State of California.

Moreover, private health care systems such as Scripps Health have rejected the federal task force's recommendation, choosing instead to keep the existing standard, which calls for a mammogram at age 40, with annual mammograms thereafter.

That means doctors will be using two medical practice guidelines, distinguished not by knowledge but by the pocketbook, said Dr. Jack Klausen, a gynecologist and obstetrician who practices at Vista Community Clinic.

''If we are in a situation where we don't screen, but the private-practice doctor can screen, then we are actually not practicing to the standard of care,'' Klausen said.

Madam President, I ask unanimous consent that this entire article be printed in the RECORD. I certainly hope that a decision like this would not be implemented in discrimination against low-income women in the State of California.

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

[From the North County Times, Dec. 7, 2009]

REGION: STATE ENDS SUBSIDY FOR MAMMOGRAMS TO LOW-INCOME WOMEN UNDER 50

(By Bradley J. Fikes)

The eligibility age for state-subsidized breast cancer screening has been raised from 40 to 50 by the California Health and Human Services Agency, which will also temporarily stop enrollment in the breast cancer screening program.

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''More than 50 percent of the women we give breast exams and mammograms to are in their 40s,'' Riley said. ''The majority of our current breast cancer survivors are women in their 40s.''

The state's decision, announced Dec. 1 and effective Jan. 1, follows a controversial federal recommendation last month that mammograms before the age of 50 are generally not needed.

However, the public health department also linked the change to California's budget woes.

The federal recommendation, made Nov. 16 by the U.S. Preventive Services Task Force, has encountered strong opposition.

The task force later retreated a bit, adjusting its recommendation to state that mammograms for women ages 40 to 49 should be

considered by their doctors on an individual basis.

Moreover, private health care systems such as Scripps Health have rejected the federal task force's recommendation, choosing instead to keep the existing standard, which calls for a mammogram at age 40, with annual mammograms thereafter.

That means doctors will be using two medical practice guidelines, distinguished not by knowledge but by the pocketbook, said Dr. Jack Klausen, a gynecologist and obstetrician who practices at Vista Community Clinic.

''If we are in a situation where we don't screen, but the private-practice doctor can screen, then we are actually not practicing to the standard of care,'' Klausen said.

In its announcement, the state said the cuts were needed because of a projected budget shortfall for the California Department of Public Health, and from declining revenue from tobacco taxes.

However, it did not say how much money it expected to save.

Calls to the department were not returned Friday.

The policy puts lives at risk, said Barbara Mannino, CEO of Vista Community Clinic.

''I bet you everybody knows a woman who was diagnosed in her 40s, and her life was saved by a mammogram, or lost because it was too late,'' Mannino said, just before leaving for her own mammogram.

And she said that little money would be saved, because all the equipment and staff to provide mammograms is already in place.

There is a difference of opinion in the medical community about when mammograms, an X-ray of the breast, should be used.

Mammograms sometimes give false alarms, with the incidence of false positives especially high for women in their 40s.

Estimates are that 10 percent to 15 percent of mammograms give false positives, experts say.

False negatives, in which the cancer is present but the mammogram seems normal, occurs 20 percent of the time, according to the National Cancer Institute.

However, false negatives become less frequent with age.

But the benefits in finding cancers when they are more easily treatable outweigh the drawbacks, Mannino and Klausen said.

And Scripps' breast cancer task force said that because 28 percent of women newly diagnosed with breast cancer are younger than 50, the number of lives saved outweighs the additional cost.

Klausen said the federal panel was trying to ''create a best-practices (standard) from a monetary point of view,'' to provide the most health care for all, out of a limited budget.

Women who get false positives on mammograms not only undergo stress, but they must go through other tests, only to find out there's nothing wrong.

That adds costs to the system without providing any better health care, according to the federal panel's reasoning.

However, Klausen said the state has taken that reasoning too far, putting too much emphasis on saving money.

''What makes me really worried is that the California Department of Public Health wants to save money by taking away a cancer-detection program,'' Klausen said. ''That discriminates against a gender, and also discriminates against an income level. And it also discriminates against how community clinics can practice medicine.''

Mr. MCCAIN. Madam President, I have found that the debate on the floor has been invigorating. I have found it to be educational not only to the Members of this body, and this Senator in particular, but I think to all Americans. Believe it or not, a lot of the deliberations and the debate and discussion we have had on the Senate floor have been vigorous. They have been sometimes passionate because this is such an important issue—issues such as the one I just discussed—and they have been sometimes tough.

But I must say, I have always tried to be respectful of the views of my colleagues, even though we have had some—especially the Senator from Illinois, the distinguished whip of the Democratic Party, whom I have engaged vigorously—but they have always been respectful debates. I intend to maintain that respect, as I have throughout my career. But I do not mean that means I will not be passionate.

So I was astonished—I was astonished—and taken aback to see a foxnews.com article that just crossed my desk titled: ''Reid Compares Opponents of Health Care Reform to Supporters of Slavery.''

Senate Majority Leader Harry Reid took his GOP-blasting rhetoric—

I am quoting from the article—

to a new level Monday, comparing Republicans who oppose health care reform to lawmakers who clung to the institution of slavery more than a century ago.

Senate Majority Leader Harry Reid took his GOP-blasting rhetoric to a new level Monday, comparing Republicans who oppose health care reform to lawmakers who clung to the institution of slavery more than a century ago.

The Nevada Democrat, in a sweeping set of accusations on the Senate floor, also compared health care foes to those who opposed women's suffrage and the civil rights movement—even though it was Sen. Strom Thurmond, then a Democrat, who unsuccessfully tried to filibuster the Civil Rights Act of 1957 and it was Republicans who led the charge against slavery.

So not only was Senator REID wrong in his accusations, Senator REID was also incorrect in who opposed slavery and who supported the Civil Rights Act. But that is not the important point. The important point, as the article goes on to say:

But Reid argued that Republicans are using the same stalling tactics employed in the pre-Civil War era.

And I quote from the article that is quoting Senator REID:

''Instead of joining us on the right side of history, all the Republicans can come up with is, 'slow down, stop everything, let's start over.' If you think you've heard these same excuses before, you're right,'' Reid said Monday. ''When this country belatedly recognized the wrongs of slavery, there were those who dug in their heels and said 'slow down, it's too early, things aren't bad enough.'''

He continued: ''When women spoke up for the right to speak up, they wanted to vote, some insisted they simply, slow down, there will be a better day to do that, today isn't quite right.''

''When this body was on the verge of guaranteeing equal civil rights to everyone regardless of the color of their skin, some senators resorted to the same filibuster threats that we hear today.''

That seemed to be a reference to Thurmond's famous 1957 filibuster—the late Senator switched parties several years later.

Sen. Orrin Hatch, R–Utah, said Reid's remarks were over the top.

''That is extremely offensive,'' he told Fox News. ''It's language that should never be used, never be used. . . . Those days are not here now.''

Sen. Saxby Chambliss, R–Ga., suggested Reid was starting to ''crack'' under the pressure of the health care reform debate.

''I think it's beneath the dignity of the majority leader,'' Sen. Tom Coburn, R–Okl., said. ''I personally am insulted.''

So this is a debate which has been spirited. This has been a debate which has been passionate. This has been a debate that I think has been very helpful to the American people. Some of the back and forth that I have seen I think has been excellent. It has been excellent debate and discussion. I enjoyed it when the Senator from Montana and I had a discussion about various endorsements. I appreciated the fact that Senator DURBIN brought my record to light and questioned it. But, most importantly, most of the conversation has been about the components of this bill and its impact on the future of America.

So to somehow compare—as this article says—we who believe firmly in the principles that are being violated by this 2,000-page legislation to people who supported slavery, I would very much appreciate it if Senator REID would come to the floor and, if not apologize certainly clarify his remarks that he was not referring to those of us who believe we are carrying out and performing our constitutional duties; that is, acting in the best interests of our constituents on an issue that will impact the future of the United States of America for years and years and years.

Madam President, I ask unanimous consent that the foxnews.com article be printed in the RECORD.

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

REID COMPARES OPPONENTS OF HEALTH CARE REFORM TO SUPPORTERS OF SLAVERY

Senate Majority Leader Harry Reid took his GOP-blasting rhetoric to a new level Monday, comparing Republicans who oppose health care reform to lawmakers who clung to the institution of slavery more than a century ago.

The Nevada Democrat, in a sweeping set of accusations on the Senate floor, also compared health care foes to those who opposed women's suffrage and the civil rights movement—even though it was Sen. Strom Thurmond, then a Democrat, who unsuccessfully tried to filibuster the Civil Rights Act of 1957 and it was Republicans who led the charge against slavery.

Senate Republicans on Monday called Reid's comments ''offensive'' and ''unbelievable.''

But Reid argued that Republicans are using the same stalling tactics employed in the pre-Civil War era.

''Instead of joining us on the right side of history, all the Republicans can come up with is, 'slow down, stop everything, let's start over.' If you think you've heard these same excuses before, you're right,'' Reid said

Monday. ''When this country belatedly recognized the wrongs of slavery, there were those who dug in their heels and said 'slow down, it's too early, things aren't bad enough.'''

He continued: ''When women spoke up for the right to speak up, they wanted to vote, some insisted they simply, slow down, there will be a better day to do that, today isn't quite right.

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''I think it's beneath the dignity of the majority leader,'' Sen. Tom Coburn, R–Okla., said. ''I personally am insulted.''

Mr. MCCAIN. So if I could return to my amendment. My amendment would make sure every beneficiary is protected and receives equal treatment. I would expect strong bipartisan support, since I think we would all like to see the same protections guaranteed for our own constituents. I know the Senator from Pennsylvania will appreciate this amendment, since he filed his own amendment to spend $2.5 billion in taxpayers' dollars to protect Medicare Advantage beneficiaries in Pennsylvania. I guess the 864,000 Medicare Advantage beneficiaries in Pennsylvania weren't satisfied with the promise to protect so-called guaranteed benefits either.

This motion to commit is straightforward and will help the President keep his promise that if you like your health insurance you have today, the policy you have today, you can keep it, and will protect 10.6 million Medicare Advantage beneficiaries from at least a 64-percent cut in benefits.

May I say, again, I think it has been an important debate we have engaged in. I do not and will not impugn the motives or the integrity of those who are sponsors of this legislation. Yes, I will argue we didn't keep the President's promise and commitment over a year ago during the Presidential campaign when he said he would have the C–SPAN cameras in, that there would be bipartisan negotiations with the C–SPAN cameras in, with Republicans and Democrats sitting down together so, in his words, the American people could see who is on the side of the health insurance companies and the special interests and who is on the side of the American people. I think that is a legitimate statement and a legitimate questioning as to the process that is taking place today, where there have been no negotiations with the Members on this side and there has been no C–SPAN camera included where these negotiations are taking place. So I hope there will be. I hope this legislation is defeated. I hope we can go back and sit down together, Republicans and Democrats, and agree on medical malpractice reform, on crossing State lines to be able to get the best insurance policy for every citizen and their family, to emphasize wellness and fitness and reward it, and to enact outcome-based treatment for our patients. I hope we can produce a lot of measures and take a lot of significant steps that would truly reduce the cost of health care in America, not enact a $2.5 trillion new entitlement program that is a scam. It is a scam because of the way the budgetary process has been set up. Right now, today, I can go out and buy an automobile, and I don't have to make a payment for a year. Under this proposal, you start making the payments and 4 years later you get the benefits. That is Enron accounting.

I hope my colleagues will allow us to continue this spirited debate and discussion. I say, with the greatest respect, these are tough issues and there are strong differences of opinion. But I think, overall, this debate and discussion is good for the American people and, hopefully, the outcome will be one where we will be better informed and can better address the issue of the skyrocketing costs of health care in America and our ability to provide them with affordable and available health care.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from New York.

Mrs. GILLIBRAND. Madam President, I ask unanimous consent that no further amendments be in order during today's session.

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

Mrs. GILLIBRAND. I yield the floor now to Senator MIKULSKI for 10 minutes.

The ACTING PRESIDENT pro tempore. The Senator from Maryland.

Ms. MIKULSKI. Madam President, I rise to speak on the bill as well as in opposition to the Nelson of Nebraska amendment on the subject of abortion.

First of all, I truly believe health care reform is the most important social justice vote we will cast in this decade. Why? Because we are talking about providing universal access to health care, which I believe is a basic human right and should be a fundamental American right. That is why health care reform is so important: To provide universal access to health care and, in this bill, ending the punitive practices of insurance companies against women, particularly in the area of gender discrimination, where we pay more and get less in our benefit package, as well as where simply being a woman is often treated as a preexisting condition.

Eight States consider domestic violence a preexisting condition and you can't get insurance. One woman who had a medically mandated C-section was told she couldn't get insurance again unless she had a sterilization—coerced sterilization in the United States of America. I thought that is what they did in Nazi Germany or in old Communist China.

The other thing this bill does is strengthen and stabilize Medicare to make sure seniors have access to health care at all ages and all stages.

I consider these principles to be pro-life. I think the health care bill we are debating is as pro-life as can be because what other thing helps maintain, protect, save, or deal with impaired life better than providing universal access to health care? A famous pastor by the name of Rick Warren, who has written the great book that has inspired so many, ''The Purpose Driven Life,'' talks not about pro-life but whole-life principles. I think being able to see a doctor or an appropriate health care professional saves lives, and I view this vote on health care reform as the most important pro-life or whole-life vote anyone can cast.

I agree with Pastor Rick Warren when he uses that principle. I believe in seeing a doctor when you need one, in saving a life, or in getting the health care you need so you don't lose an eye from diabetes, you don't lose your kidney, you don't lose your foot or, if you are pregnant and diabetic, you don't lose your child. We want to make sure women have access to mammograms, that the men we love and who love us have access if they have high blood pressure—and sometimes they have it because they don't have health care for their family—or prostate cancer. I believe that is what whole life is.

So with this bill, I believe supporting screening for diabetes is pro-life, cervical cancer screening is pro-life, but, most of all, if you want people to have healthy pregnancies, healthy childbirth, healthy babies, they need access to health care. So that is why I say voting for universal access to health care is as pro-life as you can be.

Making this debate about abortion, I believe, is misguided and wrong. First of all, in the bill, we already deal with this topic. In the interest of passing health care reform, I believe we deal with this sensitive topic in a sensitive way. We rejected shrill and strident amendments on both sides. For example, we did not seek to change the settled language regarding abortion that is the Hyde amendment.

There were those in the exuberance of last year's election who said: Oh, let's get rid of Hyde. Many of us took that position, trying to find that sensible center. We are principled and whole-life people as well. We said: Let's keep the Hyde amendment. It is settled language. I don't use the term ''settled law'' because that is a precise legal term, and I know my colleague from Pennsylvania and others can argue that, but Hyde is settled language.

What does the Hyde amendment that has been around for almost 30 years do? It prohibits any Federal funds to be

used directly for abortions, except in the case of rape, incest, or when the life of the mother is at risk. It has additional provisions that provide a conscious clause to protect providers who do not want to provide abortions. This bill does not seek to change the underlying premise of the Hyde amendment which, as I said, I regard as settled language of 30 years ago.

The pending Senate bill goes even further than Hyde. It was legislation that came out of the Finance Committee, and I salute them for, once again, trying to find a sensible center, engaging in civil and rational dialogue. I wish to compliment them on their efforts. However, the other side keeps changing the midpoint. By seeking a greater good, many of us agreed to what was in the Finance bill. Quite frankly, it went further than I would have liked if I were writing the bill, but, again, in the interest of comity we would keep this debate on the issue of providing health care and not turn it into an abortion debate.

What does what came out of the Finance Committee and what is in the merged bill do? It says loudly, clearly, and consistently: No Federal funds can be used to pay for the coverage of abortion, and it does it by separating out funds so no public money from Federal credits or subsidies would be used for abortions. What more can we ask anyone to do? Under the pending bill, health care plans cannot be required to cover abortion. Health care plans can choose to cover or not cover it, and State laws regarding abortion are not preempted. It, again, includes the longstanding practice of a strong conscience clause for either individual providers or institutions—for example, Catholic hospitals—from performing abortions if it is against their conscience.

I believe what we have done is found the sensible center, and it leaves the decision in the hands of patients and doctors, not politicians or insurance executives. So the question is not what is decided but who decides. I believe it should be in the hands of patients and doctors, not politicians or insurance executives.

Let's go to Nelson, which is a Senate version of Stupak. I reject the Ben Nelson amendment. I believe it is unnecessary. I believe it is unneeded. I believe it is uncalled for. It goes further than Hyde because it prohibits the public option from covering abortions and it prohibits individuals receiving Federal insurance subsidies from purchasing a plan that covers abortion and, even if you use your own money, it cannot be used for abortion.

It also allows women to purchase an abortion rider. Oh, boy. Is this supposed to be a big deal? Is this supposed to be the kind of thing that is supposed to make us happy? What an insulting, humiliating thing to say: If you want an abortion, go buy a rider. I think it demonizes women. Why don't you go into the workplace and paint a scarlet letter on your head. Hawthorne still lives in the Nelson amendment. Lets paint the ''A word'' on your forehead. Can you believe this? I don't know of any individual woman or any woman in consultation with the man she loves and who loves her saying: Yes, you know, we might have an abortion. Why don't we buy that rider. Nobody plans to have an abortion. It is not the subject of intimate conversations that families talk about as they plan their lives together. Do you realize the intense discrimination a woman would face? How about: Why don't we have men buy an abortion rider for the women they get pregnant? Let them buy the abortion rider. Maybe we can even give them a discount.

We are hot about this, and we are cranky about it because there is no need to do it like this. We have tried, at every step of the way, to handle this topic with great respect because there are people with principles. We are all people of principle. Some use the term ''pro-life.'' I use the term ''whole life.'' What are the rest of us? Do you think I am anti-life?

All my life as a social worker, I have fought for social justice. I fought for access to health care. And to say I am going to support a bill that denies access to services for most women in the exchange—anyway, I think this thing goes further than Hyde, and we should be debating health care, not abortion. This legislation on the Senate floor should be about women's health, like the debate we had last week about prenatal health care, how to improve delivery systems for greater survival and how to minimize birth defects. That is what it should be.

Women's health care decisions should be made by the women, in consultation with their doctor. The Patient Protection and Affordable Care Act is what we believe is a wonderful compromise, and it rejects these strident viewpoints. The most pro-life thing we can do is pass universal access to health care. The most pro-life thing we can do is stabilize Medicare so people have health care at all ages and all stages.

So reject the Nelson amendment, and if you are pro-life, vote for the Senate merged bill.

I yield the floor.

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

Mr. GRASSLEY. Madam President, for the benefit of my colleagues waiting to speak, I don't think I will speak much more than 10 minutes. Before I speak on my purpose for coming to the floor to support Senator MCCAIN's amendment, I want to take a couple of minutes to go over a source of information that is no longer credible, which has been used in debate on the floor several times, used throughout the year—information that has been in letters to the editor of Iowa newspapers.

The most recent hearing of this was when the Senator from California rose to talk about the quality of our health care and the reference to the fact that the United States is 37th out of all of the nations of the world in quality of health care.

I don't deny we have to do a lot to improve the quality of health care in America. I even admit that in this legislation, though I oppose the bulk of this 2,074-page bill, there is a lot in the bill that has to do with the enhancing of the quality of care.

We keep hearing about the United States being 37th in quality. That comes from a World Health Organization analysis that was made back in the year 2000, ranking the United States among all the other nations. It is a 10-year-old report that was flawed in its analysis at the very outset. Yet it is repeated as if gospel truth by almost anybody who wants to denigrate America's health care system and build a case for this monstrosity of a bill we have before us. When I call it a monstrosity, I will say it has some very good provisions in it that would enhance the quality of care. The World Health Organization no longer produces such a ranking table because of the complexities of the task. The rankings were flawed because they judged health care systems for problems—cultural, behavioral, and economic—that are not controlled by health care. There is no differentiation between the quality of medical systems and other factors, such as diet, exercise, and violent crime rates, which ought to be taken into consideration when considering a nation's delivering quality of health care.

The editor in chief of this 2000 report of the World Health Organization, Philip Musgrove, called the figures '' . . . many made-up numbers,'' and the result a ''nonsense ranking.'' Dr. Musgrove, an economist who is now deputy editor of the journal Health Affairs, said he was hired to edit the report's text but didn't fully understand the methodology until after the report was released. Once he left the World Health Organization, he wrote an article in 2003 for the medical journal Lancet criticizing the rankings as ''meaningless.''

The U.S. health system spends more than any other country per capita and was ranked 37th out of 191 due to that spending alone. Prior to considering how much we spend, the United States was ranked 15th, not 37th.

The Dominican Republic, Costa Rica, and Morocco ranked 42nd, 45th, and 94th before adjusting for spending levels. After the adjustment for spending levels, can you believe it? They ranked above the United States—35th, 36th, and 29th, respectively.

The United States ranked first in responsiveness. That means respect for persons and prompt attention. Americans understand and appreciate this quality care. This will be lost in this massive health care reform bill when the government takes more control.

Experts in the field of health, such as Mark Pearson, head of health for the

Organization of Economic Cooperation and Development, OECD, was quoted as saying:

It's a very notorious ranking. Health analysts don't like to talk about it in polite company. It's one of those things that we wish would go away.

I hope my colleagues will take that into consideration when they bring up the rationale for this bill, that it is because of that World Health Organization study, which I think what I said and a lot of other things you can say about it ought to put it into proper perspective.

For my support of the McCain motion to bring equalization among the 50 States for the Medicare Advantage portions of this bill, I have spent the past 28 years in Congress working to make sure that rural Iowans have access to the same quality of health care as people living in more urban areas.

Medicare, since 1965, has been a national program. Well, it is a national program with traditional Medicare. But before we brought equity to Medicare Advantage, it wasn't a national program. It was a program for California, Arizona, Texas, New York, Florida, Chicago, or near the Midwest, maybe Omaha. Since Medicare Advantage was not a national program, and since Medicare since 1965 has been a national program, I set out in the Medicare Modernization Act to bring equity to rural America just as we have in urban America. I fought to make sure that seniors living in rural areas would have the same choices as seniors living in Miami, New York City, or Los Angeles.

That is simply saying that wherever you live in the United States, you have Medicare—traditional Medicare. Before then, wherever you lived in the United States, in most rural areas you didn't have Medicare Advantage. Since Medicare is a national program, people living in rural America ought to have the same choice as those in urban America.

Today that is the case. Seniors in every county in Iowa have a choice between traditional Medicare and Medicare Advantage. That is a big improvement, since prior to the Medicare Modernization Act not all Iowans had that choice. I can narrow it down to 1 out of 99 counties—Pottawattamie County, across from Omaha, had Medicare Advantage. The other 98 counties didn't have it. I want to tell you, there are still inequities, because Iowa providers offer high-quality care that leads to less utilization. Iowans get approximately $1,500 less per year in Medicare Advantage benefits than seniors living in Florida. Under this bill, Iowans will see even less in Medicare Advantage benefits. It looks like that won't be the case for some lucky Floridians.

In another one of those backroom deals—a backroom deal that seemed to be needed to get 60 votes, backroom deals that are still being attempted to get 60 votes—the Senator from Florida, in one of these backroom deals, was able to secure a provision in the Finance Committee bill that would make sure that seniors in certain Florida counties are able to maintain their current benefits. I am not talking about the so-called guaranteed benefits that Democrats say they are protecting. The provision secured by the Senator from Florida will also protect additional and extra benefits for Floridians. In pushing for this amendment, the senior Senator from Florida said:

It would be intolerable to ask senior citizens to give up substantial health benefits they are enjoying under Medicare.

I guess Floridians weren't satisfied with the promise that has been made throughout the last 2 weeks of debate on this bill to protect the so-called guaranteed benefits. Seniors in Florida still wanted the lower cost sharing, wellness programs and vision, hearing and dental benefits they have come to rely on. Now we have the Senator from Pennsylvania filing an amendment to help Medicare beneficiaries in Pennsylvania protect their extra benefits, to get these extra benefits that people on Medicare Advantage have.

I am guessing that seniors in Pennsylvania must have also picked up on the Democrats' hollow promises to protect guaranteed benefits but not worry about other benefits. In fact, the presence of these special deals is proof that this bill is cutting Medicare benefits.

It is even proof that some Senators are worried about going back to their constituents and trying to explain the difference between cutting guaranteed and additional benefits, and explaining why they voted to cut Medicare Advantage benefits by 64 percent. Why else would these special deals be necessary?

I am here to ask my colleagues, why should seniors in Florida or Pennsylvania get to keep their extra benefits, while more than 9 million seniors in other parts of the country see an average cut of 64 percent? To quote the Senator from Florida, isn't this also intolerable?

My colleagues on the other side talk about efficiency and fairness, but they are supporting a bill that maintains the highest Medicare Advantage payments in the country, while slashing benefits in higher quality rural areas. One of those higher quality rural areas is the State of Iowa, where we are fifth in quality but near the bottom of 50 States in reimbursement on Medicare, whereas other States are fiftieth in quality and No. 1 in reimbursement on health care.

All of this doesn't sound very efficient or fair to me. Senator MCCAIN's motion is pretty straightforward. It goes State by State. I am not going to read all 50 States, but it says here that 1 million—it is going to benefit the 70,000 Medicare Advantage enrollees in Arkansas. It is going to benefit the 198,000 Medicare Advantage enrollees in Colorado. In Iowa, it is probably something in the neighborhood of 63,902. It will make sure that seniors in every other State in the country—red States and blue States—get the same deal Senator NELSON got for Florida.

A vote for the McCain amendment is simply a vote for equity. But a vote against the amendment is a vote to favor backroom deals that put the interest of a handful of Floridians above 10 million seniors across the country.

I urge my colleagues to support all seniors and vote for the McCain motion.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from New York.

AMENDMENT NO. 2962

Mrs. GILLIBRAND. Mr. President, I rise today in strong opposition to an amendment that has been offered by my distinguished colleague from Nebraska.

There has been a lot of misinformation about what the health care bill we are debating would mean for women and for reproductive rights. So let me please set the record straight.

The underlying legislation before us maintains a historic compromise we have had in this country by barring the use of Federal funds for the full range of reproductive services, except in cases of rape, incest, and to save a woman's life. That is the current law of the land, and the Senate bill goes to great lengths to maintain current Federal law.

The legislation would segregate private funds from public funds, so only a person's private money will contribute to their reproductive coverage. This is not an accounting gimmick, as some critics have falsely charged. In fact, this kind of arrangement is often used when public funds are given to parochial schools or other religious institutions to maintain a separation of church and state.

The Senate version would also require that at least one plan within the health insurance exchange offer a plan that covers reproductive services and one that does not. It would authorize the Secretary of Health and Human Services to audit any and all plans to make absolutely certain abortion is not being paid for with Federal dollars. This arrangement is squarely in line with the historic compromise we have had in this country for 30 years that keeps Federal funds from being used to pay for abortions.

As we debate the solution to the deepening health care crisis that has affected every citizen, business, and community in the country, this is not the time nor the place to instigate a new battle over reproductive rights and reproductive freedoms. Families and businesses that are getting buried under the weight of the current cost of health care deserve much better.

Proponents of the Stupak-Pitts amendment claim this is a continuation of current Federal law, but that is simply false. This proposal goes far beyond Federal law and will, in fact, bring about significant change and dramatic new limitations on reproductive access in this country. It establishes

for the very first time restrictions on people who pay for their own private health insurance. This is not partisan spin; this is fact. A new study by George Washington University School of Public Health and Health Services concluded:

> The treatment exclusions required under the Stupak/Pitts amendment will have an industry-wide effect, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange.

This is government invading the personal lives of Americans, and it puts the health of women and young girls at grave risk.

In fact, this amendment would represent the only place in the entire health care bill where opponents are actually correct. This would truly limit access to medical care by giving the government the power to make medical decisions, not the patient or the doctor.

We all agree it is important to reduce abortions in this country, and I will continue to work in many ways to reduce unintended pregnancies and to promote adoption. However, the Stupak amendment prohibits the public plan as well as the private plans offered through the exchange, if they accept any subsidized customers, from covering any abortion services. This effectively bans full reproductive coverage in all health insurance plans in the new system, whether they are public or private.

Creating a system in which women are forced to purchase a separate abortion rider is not only discriminatory, it is ridiculous. It would require women to essentially plan for an event that occurs in the most unplanned of circumstances and often in critical emergency situations.

There are currently five States that require a separate rider for abortion coverage. In these five States, it is nearly impossible to find such a private insurance policy that covers full reproductive care. In one State, one insurance company holds 91 percent of the State's health insurance market and refuses to even offer such a rider.

There is no doubt that a lack of access to full reproductive health care puts the lives of women and girls at grave risk. The Stupak measure poses greater restriction on low-income women and those who are more likely to receive some kind of subsidy and less likely to be able to afford a supplemental insurance policy.

Denying low-income women reproductive coverage in this way is not only discriminatory, it is dangerous. Without proper coverage, women will be forced to postpone care while attempting to find the money to pay for it. Such a delay can lead to increased costs and graver health risks, particularly for these younger girls or these women will be forced to return to dangerous back-alley providers. Women and girls in America deserve better.

I am optimistic we can defeat this radical change to Federal law, pass a health care bill in the Senate that respects current law, and strip the dangerous Stupak measure during the conference process. As I said before, I think there has been a lot of misinformation about what the Stupak measure does and the level of danger this kind of sweeping change could pose to women and girls.

This health care package must move us forward toward quality, affordable health care for every single American.

I ask my colleagues to oppose the Nelson amendment and any similar measure. I ask that we work together to preserve current law and respect the private choices made between a woman and her doctor.

Madam President, I yield the floor.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from Pennsylvania.

Mr. SPECTER. Madam President, I have sought recognition to join Senator BOXER, Senator MIKULSKI, and Senator GILLIBRAND in opposing the Stupak amendment.

The controversy set forth on this issue has been debated in this body and in the House since the Hyde amendment was enacted in 1977. What is attempted by the pending amendment in the Senate and the Stupak amendment in the House is to alter that to the disadvantage of a woman's right to choose.

The decision in Roe v. Wade in 1973 was admittedly and obviously viewed as a landmark decision which recognizes the constitutional right of a woman to choose. There have been some limitations drafted as we have moved through the process. We have had many debates on this floor on the Mexico City policy, and many aspects have been subject to challenge. But the provision which is in the bill presented by the distinguished majority leader, Senator REID, the pending bill, maintains careful delineation which has been worked out up until this time; that is, there would not be any Federal funds used for abortion, but there would be no limitation on the ability of a woman to have abortion coverage if she chooses to so long as she paid for it herself.

The provisions in the statute are very plain. Section 1302(2)(a) provides for the prohibition on the use of Federal funds. I am inserting the meaning of the language where it has references to many subsections. But the prohibition on the use of Federal funds states, in effect, that if a qualified health plan provides coverage of services for abortion, the issuer of the plan shall not use any of the Federal funds for abortion. Then there is a provision on segregation of funds, section 1303(2)(b), which provides, in effect, in the case of a plan which covers abortions, the issuer of the plan shall segregate an amount equal to the cost of services for medical services other than abortion from the cost of medical services for abortions. That sets it out about as plainly as you can.

The precedent on Medicaid coverage, which involves Federal funding, where some 23 States have chosen to add abortion coverage where the States are putting up their own money, so that there are no Federal funds involved but the Medicaid services do cover abortions, but they are with funds other than Federal funds—State funds—it is just the same analogy as no Federal funds under this bill but with moneys provided by the woman who wants the coverage for herself. The precedent from Medicaid, it seems to me, is totally dispositive of the matters of public policy.

Also, it ought to be noted that there is some 87 percent of insurance in the private market which covers abortions. Insurance in the private market provided by employers has the feature of deductibility. So while there is not a direct payment by the Federal Government on policies which do cover abortions, there is an indirect factor here because there is a tax break. The Federal Government does not get taxes on items which the employer deducts on the cost of the insurance coverage.

There is also a consideration on an underlying issue of discriminatory practices as to women on the limitation of what is reasonable medical coverage. There is an analogy—none of the analogies are really compelling, but the argument has been made that where you have a pharmaceutical coverage on Viagra, for example, which deals with reproductive capacity, nobody would think of saying the pharmaceutical coverage ought to be limited. Similarly, where there is the right to an abortion, if a woman wants to have it, which she pays for herself, it has all of the ring of discrimination.

A principal concern which I have is that if this issue results in a stalemate, the entire bill will be defeated because of this issue.

There are two remaining matters to be resolved which have some significant import which could lead to the defeat of the bill. One is on the issue of the public option. It is my argument, contention that we still ought to have a robust public option. There is a vast misunderstanding that the public option does not mean that the Federal Government is taking over on insurance coverage. That is single payer. That is not the public option, which is what it says, an option, one alternative. There are efforts being made to find an accommodation. I hope we stick with a robust public option.

The other issue which could lead to defeat of this bill, bring it down, is this controversy on abortion. It is still unclear how the Stupak amendment emerged in the House bill. There are lots of objections to it. Why the dichotomy of Hyde with no Federal funds being used and people could pay for their own was not followed in the House bill I do not know. I do not ascribe any inappropriate motives to any

of my colleagues. I would not do that. But I think a consequence of this controversy—and I think there may be some who do want to kill the bill. Certainly, the delaying tactics on the other side of the aisle make it plain that there are those who would use whatever procedures are available, whatever arguments are available to defeat the bill. That would be very regrettable in terms of the long struggle. We have discussed this on the floor again and again, what has happened since Theodore Roosevelt, FDR, and the efforts made to have coverage of health care for the uninsured.

If we stalemate on this issue, that could be the consequence. There is no reason to stalemate when there is such a clear-cut path. The bill explicitly provides that no Federal funds may be used for abortion, that any Federal funds would be segregated. That is the precise precedent of Medicaid. So I urge my colleagues to defeat the pending amendment so we can proceed to move for final enactment of this important legislation.

I thank the Chair and I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Madam President, I rise to speak in opposition to the Nelson-Hatch amendment, which replaces the compromise language in the current bill with unprecedented restrictions on women's access to safe and legal abortion services.

I think we can all agree that women's health is fundamental to our Nation's health. We all know that when women are healthier, families, communities, and countries are healthier. But I also know the issue of abortion is difficult, no matter where you stand on it, and I truly respect the fact that we have a range of opinions among us. Women have abortions for different reasons. Some of these reasons may not seem right to some of us. But even if we disagree, it is better that each woman be able to make her own decision with her doctor.

In a perfect world, no woman should have to face the decisions we are discussing today. But the reason we have insurance coverage is to help us deal with the unexpected. No woman expects to have an unplanned pregnancy. No woman expects to end a wanted pregnancy because of fetal anomalies or risks to her own health. If we limit options in private health insurance coverage, we take away a woman's right to make a decision that may be best for her and for her family in their circumstances.

But unplanned pregnancies do occur, and we have a responsibility to provide women with the full range of choices regarding their health. The Supreme Court has repeatedly ruled on this issue and made it clear that women have a constitutional right to access abortion. It is our responsibility to make sure abortions are safe, legal, and rare.

Supporting a woman's right to make decisions about her health means more than keeping abortion services legal; it means supporting a woman's decision to terminate a pregnancy safely and with dignity. It also means teaching honest, realistic sex education. It means the right to choose contraception. It means standing with women who choose to continue their pregnancies—with the hope and expectation that a compassionate society will support them in their responsibilities raising a child. It is about respecting women's personal decisions and the challenges they face, especially at times when they are the most vulnerable.

I strongly oppose the Nelson-Hatch amendment because it undermines the status quo and breaks new ground by restricting women's fundamental rights. The amendment stipulates that health plans cannot cover abortion services if they accept even one subsidized customer, even if the abortion coverage would be paid with the private premiums health plans receive directly from individuals. If adopted, this would mark the first time in Federal law that we would restrict how individuals can use their own dollars in the private health insurance marketplace.

I also oppose the amendment because we have a workable solution. The existing compromise in our bill represents genuine concessions by both pro-choice and pro-life Members of Congress. The current bill prohibits Federal funding of abortion but also allows women to pay for abortion coverage with their own private funds. It makes clear abortion can't be mandated or prohibited and stipulates that Federal funds cannot be used for abortion.

Let me be clear. The compromise within the current bill is as far as we can go. We have negotiated to get to this point. We cannot negotiate further without literally undermining the compromise we have made on behalf of women's health in this country.

We are on the verge of passing a historic health reform law that will do more to improve the health of women and families than any legislation in recent history. We will end discrimination based on health history, on gender, or history of domestic violence. We will provide access to preventive health services so women can get annual exams and mammograms at no cost. It is our responsibility to guarantee women are not worse off—under the health reform we are going to pass—than they are today.

As my friend Paul Wellstone used to say: ''If we don't fight hard enough for the things that we stand for, at some point we have to recognize that we don't really stand for them.'' I urge my colleagues to stand with me today to oppose this amendment.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWN. Madam 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. Madam President, I am troubled by what I have seen in the Chamber of the Senate in the last week. Actually, I am troubled by what I have seen in the Senate Chamber for the last several weeks, as I have watched this slow walk that so many of my colleagues who oppose health care reform are doing—anything to stall, anything to slow things down, anything to distract the public.

It began last summer, when some negotiations were going on. It was pretty clear there was no interest in any kind of real compromise, in any kind of constructive input into these negotiations. I can say that because I remember what happened in the Health, Education, Labor, and Pensions Committee in July. In June and July, we wrote the original—the first health care bill that passed a Senate committee, the HELP Committee.

We processed hundreds of amendments. The markup—which is the discussion inside the committee—took 11 days, the longest markup in anybody's memory. Everybody got a chance, everybody—all 23 Members of the committee, 13 Democrats, 10 Republicans—to offer amendments. Most of those amendments were voted on or agreed to. Nobody filibustered.

There was certainly lots of discussion. Sometimes we are a little long-winded around here, more so than we should be, but 160 Republican amendments were passed—either agreed to or actually voted on and passed in the committee. I voted for most of those amendments—I would say probably all but 10 of them—something like that. But the point is, there was a lot of bipartisanship in this legislation.

On the bigger questions, the differences are more ideological, more fundamental. For instance, Democrats support a strong Medicare. Republicans, who originally opposed Medicare in the 1960s—and not for partisan reasons but for ideological reasons—do not think government should run Medicare. That was pretty clear.

In the 1990s, when I was a Member of the House, Speaker Gingrich and the Republicans—they had a majority in the House and Senate—tried to privatize Medicare. President Clinton mostly blocked it, although he went along with some of it. When the Republicans, for the first time, had the House, the Senate, and the White House, in 2003, they dramatically privatized Medicare, shoveling all kinds of moneys into the insurance companies and giving huge subsidies to the drug companies. Look what we got. We got more difficult problems with Medicare, more budget problems. We went from a budget surplus to a budget deficit, partly because of that bill and because of the war.

My point is, this bill was bipartisan in many ways, but on the big fundamental questions—should government be involved in things such as Medicare; what should we do on worker safety issues; what to do on consumer protections—the Democrats want to see strong consumer protections, with no more cutting people off their coverage because of preexisting conditions, no more discrimination against women.

As the Presiding Officer knows, through her work in New Hampshire, she has seen too many of her female constituents paying higher prices than male constituents. What is fair about that? So the Republicans have generally sided with the insurance companies and the Democrats generally side with consumers. On those fundamental questions, they aren't really partisan as much as they are ideological.

Saturday night, a couple weeks ago, when we actually began the debate—where no Republican voted to allow the bill to even be debated—that was the ultimate stall tactic, to keep it off the floor. The Democrats voted to put it on the floor. But what bothers me about this stalling is not just that they are stopping us from doing what we need to do in this country, it is that in my State alone, there are 400 people every single day—from Toledo to Athens, from Bryan to St. Clairsville, from Conneaut to Middletown—400 Ohioans every day lose their insurance, 400 Ohioans every day. Across the country, 45,000 people die every year, according to studies, and 1,000 people a week die because they don't have insurance.

As the Presiding Officer knows, because of her work on women's health care, a woman with breast cancer, without insurance, is 40 percent more likely to die than a woman who has breast cancer with insurance.

Think about that. If you have breast cancer, as anxious as you are, as fearful as you are, as sick as you are, if you have insurance you at least do not have to worry about that; you can go get decent medical care and many times your life is saved, particularly if you caught it early enough. But if you don't have insurance, you can't go to the emergency room. They are not going to take care of you every day. They might take care of you at the end of your life, right at the end; if you are dying you might get emergency care. But people like that are just left out of the system. That is why a woman with breast cancer without insurance is 40 percent more likely to die. That is why these delays from my friends over there, they write memos on the best way to delay the bills. They try every motion they can think of. For 3 days we couldn't even get a vote when we wanted to vote on one of their amendments, Senator MCCAIN's amendment on Medicare. We literally could not get a vote because the Republicans blocked the vote. We finally did.

It is just these delay tactics. Again, 400 people in Findlay and Mansfield and Zanesville and Springfield and Xenia and Columbus—400 people every day lose their insurance in my State alone. Forty-five thousand people die a year because they do not have insurance.

Let me read a couple of letters. I come to the floor most days and read letters from people from my State. Many of these letters—not every one, but many of them—come from people who, if you asked them a year ago, would have said they had pretty good insurance. Then they have a child born with a preexisting condition, and they lose their insurance or then maybe they got sick and their hospital bills were so high the insurance company cut them off. Maybe they lost their job and they lost their insurance.

So many of those letters, as I said, were from people who thought they had good insurance and found out when they really needed the insurance, it was not such good insurance.

Let me just read from a couple of letters. This comes from Amy from Franklin County. Franklin County is in the middle of the State, the State capital located in Franklin County.

I recently had two minor surgeries. But in the last six months alone, I've had to spend about $4,000 to cover 15 percent of my income. Thank you for taking a strong stance on health reform.

What Amy writes about, when you are spending one-sixth of your gross income on health care—then this is somebody who is working, she is playing by the rules, she is doing everything she can, and she got really sick—there was not the safety net for her that there should be.

Our bill will take care of that. Our bill says if you have health insurance and you like it, you can keep it, but in addition you are going to get good consumer protections, no more preexisting condition, no denial of care that way.

A second thing: If you are a small business you are going to get assistance—some tax incentives, some tax incentives, some tax credits—to insure your employees. Most small business people I know in Bucyrus, OH, in Galion, in Crestline, in Shelby, and all over my part of the State, like that. Most of them want to cover their employees, but if you have 20 employees and one of them gets sick, your insurance rates will go so high you can no longer afford it sometimes or you will get cancelled.

The third thing our bill does is it helps people, those who do not have insurance, by giving them assistance so they can afford insurance, so people like Amy can get a better insurance policy rather than spending that much money out of pocket.

The other letter I would like to share is from Amber from Morrow County, an area of the State sort of north-central, north of Columbus, Mount Gilead, that part of the State, Cardington. She says, at age 19—this is more a story about her than an actual letter—at age 19 Amber was discontinued on her stepfather's insurance plan because of a preexisting condition. Needing constant medication and treatment for her diabetes, she tried to obtain her own health insurance plan. She was unable to afford any of her treatments or medications because she couldn't get insurance. As a result of an inability to treat her condition, she suffered two heart attacks and lost most of her vision.

She is 22 years old now. Now legally blind, she has lost feeling in her hand and feet, missing many of her teeth, and has kidney and intestinal problems. She feels lucky now to qualify for government disability benefits.

I don't know Amber. I know what her family members sent to us about her. But because she could not get insurance, because she was taken off her stepfather's insurance because of a preexisting condition, she was not able to do the kind of care diabetics are able to do.

It is a horrible disease. My best friend had diabetes. We have friends and neighbors and family members and colleagues and associates who have diabetes. Most of them, if they have a good health insurance plan, are able to live normal lives and don't have these kinds of things happen that happened to Amber.

What has happened, lost feeling in her hands and feet, kidney and intestinal problems, all the awful things that come out of diabetes are because it is a chronic disease. They are manageable. You know what will happen. Amber ends up in the hospital. Because she doesn't have insurance, it costs others in Morrow County who have insurance. They all pay more because they have to take care of Amber in a very expensive situation instead of providing insurance for Amber so she can manage her diabetes at much less cost and much more humanely.

It simply doesn't make sense to continue to stall. I have been around a good while in government. I have never been more upset than I have watching these stall tactics. These are not games people should be playing when you think about the human life, you think about Amber, you think about Amy, you think about how we all have people in our States who have suffered because they do not have insurance. We know how to fix it. We need to move forward and get this done as quickly as we can.

Four hundred Ohioans losing their insurance every day; 45,000 Americans dying every year because they don't have insurance. Those things simply are not acceptable.

I yield the floor.

Mr. KOHL. Madam President, with America aging at an unprecedented rate, and with the high and rising costs of caring for a loved one, the financing of long-term care must be addressed if we are going to get health care costs under control. For those who can plan ahead while they are still healthy, and who can afford it, private long-term care insurance may play a helpful role

in enhancing their retirement security—but only if the policies they purchase are sound and the protections are strong.

We all know that long-term care is expensive. The cost of care in a nursing home now averages $75,000 per year. However, most Americans do not realize Medicare provides only very limited assistance through home health services, and that Medicaid will not cover long-term care costs unless their household savings are nearly eliminated. States share the responsibility of providing Medicaid funding for long-term care with the Federal Government, and are also looking for ways to reduce their expenses. As of today, 43 States are in the process of launching ''partnership'' programs, which provide consumers who purchase private long-term care insurance and exhaust their benefits the ability to retain higher assets than are normally permitted if they go on to receive services under Medicaid.

We have a duty to try to ensure that these policies, which often span decades, are financially viable. During the last several years, several long-term care insurance carriers have fallen into financial difficulties, raising questions about how protected policyholders' investments are, and others have sharply raised premiums to compensate for actuarial miscalculations. Such premium increases can be devastating for older persons who are living on fixed incomes. Their choices are often stark and very limited: they can either dig deeper and pay the increased premiums, or let their policy lapse, leaving them with no coverage if they ever need care.

Last year, I was joined by several Senate and House colleagues in releasing a GAO report on whether adequate consumer protections are in place for those who purchase long-term care insurance. The report found that rate increases are common throughout the industry, and that consumer protections are uneven. While some States have adopted requirements that keep rates relatively stable, some have not, leaving consumers unprotected.

The amendment I am cosponsoring with Senators WYDEN and KLOBUCHAR will help mitigate these problems and do a better job of protecting policyholders who buy policies in the future. We need to strengthen standards for all policies to ensure that premiums increases are kept to a minimum; that insurance agents receive adequate training; and that complaints and appeals are addressed in a timely manner. We also need to make it easier for consumers to accurately compare policies from different insurance carriers, particularly with regard to what benefits are covered and whether the plan offers inflation protection. States should also have to approve materials used to market Partnership policies. This amendment will institute these and many other improvements.

It is estimated that two out of three Americans who reach the age of 65 will need long-term care services and supports at some point to assist them with day-to-day activities, and enable them to maintain a high-quality, independent life. Long-term care insurance is an appropriate product for many who wish to plan for a secure retirement. But to be a viable part of the health care solution, we must take the necessary steps to guarantee that consumers across the country have adequate information and protections, and that premiums won't skyrocket down the road.

I am pleased to say that this policy is strongly supported by the National Association of Insurance Commissioners and the Wisconsin Office of the Insurance Commissioner, Consumers Union, Genworth Financial, Northwestern Mutual, the National Treasury Employees Union, and California Health Advocates, which provides support to that state's insurance counseling and advocacy programs.

I urge my colleagues to support this vital amendment.

MORNING BUSINESS

Mr. BROWN. Madam President, I ask unanimous consent the Senate proceed to a period of morning business with Senators permitted to speak therein for up to 10 minutes each.

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

LAKEWOOD POLICE SHOOTINGS

Mrs. MURRAY. Madam President, tomorrow will be a somber and very difficult day in my home State.

That is because tomorrow, just over a week after the single worst act of violence against law enforcement in Washington State history, police officers from across the State and Nation, heartbroken Washington State residents, the community of Lakewood, WA, and the families of the victims of last Sunday's brutal attack on four police officers will gather to say goodbye.

Tomorrow's memorial for the four officers killed on the morning of November 29th will begin with a procession that leaves from just steps away from the coffee shop that was the site of that senseless and cowardly attack.

An attack in which four officers were targeted solely because they were in uniform, solely because they had sworn to protect their community.

The procession will then weave its way through that very community—Lakewood, WA, a community that has been devastated by this tragedy, a community where these four officers were original members of their police force—and were loved and respected by their colleagues and the people they served.

Along the way, the procession route is expected to be lined by thousands of Lakewood residents and by all those who have been so deeply affected by this tragedy from throughout my State.

At the Lakewood Police Department the procession will stop to pick up the families of the fallen officers—families who together now include nine children left without a parent—families whose grief is hard to imagine.

The procession will end at a service that is expected to be attended by more than 20,000 law enforcement officers from every corner of my State and from throughout the Nation.

It will be an emotional end to a week that has rocked my home State.

It will also be farewell for four police officers who devoted and ultimately gave their lives to protect others.

Law enforcement is not for everyone. In fact, it takes a special kind of person to be willing to wake up each day—motivated and ready to be the line of protection between dangerous criminals and our neighborhoods and people.

But in the case of Sergeant Mark Renninger and Officers Gregory Richards, Tina Griswold and Ronald Owens it is easy to see where they got that motivation from.

When you hear their life stories, it is clear that, to a person, these were officers who beyond all else, were dedicated to family; officers who knew that the work they did protected those they love and families just like theirs.

In a telling quote this week, a fellow Lakewood officer described his fallen colleagues by saying that they were executed because they were cops, but that none of them saw their lives that way.

Instead he said they saw themselves first and foremost as family men and women.

For these four police officers any reminder of just how critical the duties they performed each day were came when they went home each night.

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

In memorials he has been described as a glass-half-full guy, someone who made things better for the people around him. His wife Kelly has talked this week about his passion for music, his job and of course his family.

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

She stood 4 foot 11 but as her colleagues have said many times—she wouldn't back down from anyone. She was a member of the riot response team, a hard-charging officer and mom who loved her job and her family.

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

He has been remembered as spending almost all of his off-duty time with his daughter—attending all of her school

functions, riding bikes together, and treating her to nights out whenever he could.

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

He was an Army Ranger and has been described as having the kind of natural leadership abilities that put other officer at ease in difficult situations.

He was a SWAT team trainer known for an enthusiasm for his job. But he was also remembered this week for the joy that family brought him—whether it was trips to Mariners games or family vacations to Mount Rainier.

This was a senseless and brutal killing—and it specifically targeted the people who sacrifice each day to keep all of us safe.

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

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

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

Already this year more than 100 police officers across our country have given their lives while serving to protect us.

Each of these tragedies sheds light on just how big a sacrifice our police officers make in the line of duty.

But these most recent attacks in my home State also offer an important reminder that our officers are always in the line of duty, even when they are training other officers, out on routine patrols, or simply having coffee.

There is no doubt that these senseless attacks have left many law enforcement officers across my State and our country feeling targeted. But there is also no doubt that their willingness to put themselves on the line to protect us will continue unshaken. That is a testament to the commitment they make to serve and protect us every day, and it should remind all of us that these brave men and women deserve all the support we can provide to keep them safe.

As my State prepares to say goodbye to these four heroes, I again extend my condolences and the condolences of the entire Senate to their families.

Our law enforcement professionals put themselves between us and danger every day. Right now, in light of such horrible events, we hold them even closer in our own thoughts and prayers.

PEARL HARBOR ANNIVERSARY

Mr. AKAKA. Madam President, I rise in remembrance of the attack on Pearl Harbor, the ''Day of Infamy,'' 68 years ago today.

I had other things on my mind when I woke up on the morning of Sunday, December 7, 1941. I was 17 years old and studying at the Kamehameha School for Boys. I climbed to the roof of my dormitory in the foothills above Pearl Harbor—and saw the planes swarm. I watched as their bombs and torpedoes delivered a crippling blow to the Pacific fleet. I saw smoke rise to the sky as the USS *Arizona* and other battleships sank.

When the planes flew over our campus for a second bombing run in Kaneohe, close enough to see the unmistakable red sun of imperial Japan, I confirmed what I had feared: we were under attack. I did not know what would happen next, but I knew for certain that my life, Hawaii, the United States, and the world would never be the same.

As an ROTC cadet, I spent the rest of that day in the foothills above our campus, searching for paratroopers. Later, I joined the Army and served as a noncommissioned officer in the Pacific.

Hawaii changed immediately. Martial law was declared. A military governor was appointed. Food and supplies were rationed. The people of Hawaii were subjected to a curfew, and sat in darkness all night—lights were banned to make it harder for the enemy to find the islands.

The terrible attack inspired a generation of young people to set their lives and dreams aside to fight World War II. When we returned home, victorious, we returned to a grateful Nation. Thanks to the G.I. bill and other reintegration efforts, these young veterans went on to become The Greatest Generation: Presidents, Nobel laureates, and leaders in their communities.

We who lived through Pearl Harbor and fought World War II know too well that today's service men and women face challenges similar to those from our youth. So does our Nation. But we benefit from the lessons of World War II: that our warriors can do great things if they return to a grateful Nation that provides them with the care and support they have earned.

World War II changed our country forever, revolutionizing our defense forces, industrializing our Nation, and leading the United States to assert its global leadership and become the world's superpower.

As we pause to remember those lost on the ''Day of Infamy,'' let us also honor those who are overseas fighting today, and all those who have sacrificed to defend our great country over the years.

Like the veterans of World War II, today's servicemembers and former servicemembers can achieve great things if they are supported by the Nation they have defended. With that in mind, let us show our thanks by honoring our veterans and preserving the Union they risked everything to protect.

Mr. LEMIEUX. Madam President, 68 years ago today, the United States was thrust into World War II following the surprise attack on Pearl Harbor. Today, we pay tribute to those who survived the attack and remember the men and women who perished.

Although the attack claimed the lives of more than 2,300 Americans, it did not break the resolve of our military. Today, we are grateful for the service of those we lost in conflict as well as those who returned after fighting to keep us safe and free. I join all Floridians in honoring those who fought for our freedom on that day and throughout the ensuing campaigns in Europe and the Pacific.

On this Pearl Harbor Day, I thank all World War II veterans who answered our Nation's call to serve in the cause of freedom. They are true heroes and our Nation will always remember their sacrifice.

HONORING OUR ARMED FORCES

LIEUTENANT COLONEL JAMES GENTRY

Mr. BAYH. Madam President, I rise today to honor the life of LTC James Gentry, commander of the 1st Battalion, 152nd Infantry of the Indiana National Guard.

Jim was only 52 years old when he tragically lost his long and heroic battle with cancer on November 25, 2009, the day before Thanksgiving.

A native of Mitchell, IN, he served two tours of duty in Iraq. It was in Iraq in 2003 where Lieutenant Colonel Gentry and the more than 600 soldiers he bravely led were exposed to the lethal chemical sodium dichromate while guarding the Qarmat Ali water treatment facility in Basrah.

In 2006, Lieutenant Colonel Gentry was diagnosed with terminal cancer and given 2 months to live. He not only valiantly fought this debilitating illness—and survived much longer than doctors expected—but he also fought to bring crucial details about the tragedy at Qarmat Ali to the Nation's attention.

With his quiet courage, he advocated for justice for the soldiers under his command until his final days. Due in large part to his efforts, the Department of Defense is now investigating why so many service men and women were exposed to this deadly chemical.

As Americans, we take pride in the example Lieutenant Colonel Gentry set as a soldier, a leader, and a patriot. I had the privilege of speaking with him on the phone a little more than a month ago. Even in what turned out to be his final days, he remained steadfast in his dedication to his troops and in his efforts to ensure they received proper care.

Jim is survived by his devoted wife LouAnn Grube Gentry, five children Sarah Clark, Jason Newman, Emily

Gentry, Jennafer Newman, and Ellen Gentry, his parents George and Brenda Sue Gentry, brother Sanford Gentry, and sister Carolyn Hodges.

Lieutenant Colonel Gentry was a brave man who put his soldiers before himself, both on and off the field of battle. Today and always, he will be remembered by family and friends, fellow soldiers and all Hoosiers as a true American hero. We cherish the legacy of his service and his life.

It is my sad duty to enter the name of LTC James Gentry in the RECORD of the U.S. Senate for his service to this country and for his profound commitment to freedom, democracy, and peace.

AMINATOU HAIDAR

Mr. LEAHY. Madam President, last week I spoke about the situation of Aminatou Haidar, a Sahrawi human rights activist who has been on a hunger strike since shortly after November 13 when her passport was confiscated by Moroccan authorities and she was deported to the Canary Islands. She is now in the third week of her hunger strike, and her health has seriously declined. An agreement between the Spanish and Moroccan governments was reportedly reached on Friday, but it fell through at the last minute and Ms. Haidar remains at the Lanzarote Airport.

Given this dire situation and the damage it is causing to efforts to resume good-faith negotiations on the future status of the Western Sahara, I want to repeat my appeal to the Moroccan authorities to reinstate Ms. Haidar's passport and allow her to return home to her family.

Morocco and the United States are friends and allies. The denial of citizenship and forcible exile of Ms. Haidar is inconsistent with international human rights norms to which Morocco is a signatory and will accomplish nothing positive. It also raises the question, as do the recent arrests of other Sahrawi activists, of whether the United Nations' mandate in Western Sahara should be expanded to include human rights monitoring. I believe the State Department should seriously review this issue when the UN mission's term comes up for extension in the Security Council in April.

There is still time, but it is running out, to resolve this issue in a manner that serves Morocco's interests and protects Ms. Haidar's rights.

ADDITIONAL STATEMENTS

REMEMBERING MITCH DEMIENTIEFF

• Mr. BEGICH. Mr. President, I wish to remember the life of a much respected and accomplished resident from my home State of Alaska, Mr. Mitch Demientieff of Nenana. Mitch passed away on December 1, 2009. He was 57.

Mr. Demientieff not only held many important positions in the Native community, he was an ardent preserver of his Athabascan culture and a true family man. While a student at the University of Alaska Fairbanks, he accomplished something truly amazing: at age 19, he was elected president of the Tanana Chiefs Conference, a post he held again years later. One year before his election as president, he broke into the local political scene as mayor of Nenana.

His legacy at the Chiefs included the modernization of the tribal health programs and working to provide education to the youth in the Native community. His personal legacy revolves around his dedication to preserving Native culture. Mitch was committed to making sure the traditions of Alaska Natives and his people were not lost. His interests included the stories he heard and passed on, traditional songs and dances, how clans were run and the practices of traditional medicine.

His achievements later in life included service on the Federal Subsistence Board where he was a strong advocate for subsistence rights for Natives. At the time of his passing, he was serving on the Nenana City Council and was the Nenana tribal chief.

In his personal life Mitch was an avid sports fan and coach who was loved by his family and community. He and his wife Kathleen, married for 24 years, have a blended family of six children and 14 grandchildren. Mitch was both beloved and respected in their community and throughout interior Alaska. Everywhere Mitch went, he made friends.

Mitch Demientieff will be missed by his family, friends, and all of the people he touched in the State of Alaska.•

TRIIBUTE TO DR. JAMES A. (DOLPH) NORTON

• Mr. VOINOVICH. Mr. President, I wish to congratulate a distinguished American public administrator, Dr. James A. (Dolph) Norton, who is being awarded the 2009 George Graham Award for Exceptional Service by the National Academy of Public Administration, NAPA. NAPA is a congressionally chartered national institution created to help governments serve the public better and achieve excellence. Dr. Norton's career in public service stands as a shining example and testament to the high ideals of public administration that NAPA represents. His diverse and numerous accomplishments serve as an inspiration to those who may also aspire to careers in public administration.

During the course of his outstanding career, Dr. Norton earned degrees from both Louisiana State University and Harvard University. He served with distinction on the faculties at Florida State University, Case Western Reserve University, and the University of Virginia. He went on to become the chief executive officer of several organizations during times of notable achievement. He directed a comprehensive research study on urban governance for the city of Cleveland, served as director of the Greater Cleveland Associated Foundation and director of the Cleveland Foundation, the Nation's oldest and then-largest community foundation, and as chancellor of the Ohio Board of Regents as the State innovated funding for centers of excellence at universities.

In retirement he answered the call to serve from several institutions of higher education throughout the Nation by providing the unique skills necessary to manage their transition from one generation of leadership to another. He served with distinction as interim chancellor of the University of Maryland System, interim president of Hiram College in Ohio, interim president of Adelphi University in New York, interim president of Bryant College in Rhode Island, interim chancellor of Lamar University System in Texas, and interim president of Central Washington University.

I commend Dr. Norton for his lifelong dedication to public service and outstanding leadership, and congratulate him on his award.•

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–3900. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Transactions Between Member Banks and Their Affiliates: Exemption for Certain Purchases of Asset-Backed Commercial Paper by a Member Bank from an Affiliate'' (Regulation W; Docket No. R–1331) received in the Office of the President of the Senate on December 2, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3901. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Transactions Between Member Banks and Their Affiliates: Exemption for Certain Securities Financing Transactions Between a Member Bank and an Affiliate'' (Regulation W; Docket No. R–1330) received in the Office of the President of the Senate on December 2, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3902. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Risk-Based Capital Guidelines; Leverage Capital Guidelines'' (Regulations H and Y; Docket No. R–1332) received in the Office of the President of the Senate on December 2, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3903. A communication from the Secretary of the Interior, transmitting, pursuant to law, a report relative to using private contributions to acquire land adjacent to a designated wilderness area in Lassen Volcanic National Park; to the Committee on Energy and Natural Resources.

EC–3904. A communication from the Director, Office of Surface Mining, Department of

the Interior, transmitting, pursuant to law, the report of a rule entitled ''Utah Regulatory Program'' (SATS No. UT–046–FOR) received in the Office of the President of the Senate on December 2, 2009; to the Committee on Energy and Natural Resources.

EC–3905. A communication from the Chief of the Endangered Species Listing Branch, Fish and Wildlife Services, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Endangered and Threatened Wildlife and Plants; Revised Designation of Critical Habitat for Cirsium loncholepis (La Graciosa Thistle)'' (RIN1018–AV03) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3906. A communication from the Secretary of Labor, transmitting, pursuant to law, a report relative to the impact of the Andean Trade Preference Act on U.S. trade and employment through 2008; to the Committee on Finance.

EC–3907. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Net Operating Loss Carryback Election under Section 13 of the Worker, Homeownership, and Business Assistance Act of 2009'' (Rev. Proc. 2009–52) as received during the adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Finance.

EC–3908. A communication from the Chief of the Border Security Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Extension of Port Limits of Columbus, Ohio'' (CPB Dec. 09–35) received in the Office of the President of the Senate on December 2, 2009; to the Committee on Finance.

EC–3909. A communication from the Acting Executive Secretary, U.S. Agency for International Development, transmitting, pursuant to law, a report relative to seven (7) vacancies in the agency; to the Committee on Foreign Relations.

EC–3910. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency's response to the GAO report entitled ''Democracy Assistance: U.S. Agencies Takes Steps to Coordinate International Programs but Lack Information on Some U.S.-funded Activities''; to the Committee on Foreign Relations.

EC–3911. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency's response to the GAO report entitled ''International Food Assistance: USAID Is Taking Actions to Improve Monitoring and Evaluations of Nonemergency Food Aid, but Weaknesses in Planning Could Impede Efforts''; to the Committee on Foreign Relations.

EC–3912. 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; North Carolina; Clean Air Interstate Rule'' (FRL No. 9086–2) received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009; to the Committee on Environment and Public Works.

EC–3913. 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; Illinois; Indiana; Chicago and Evansville Nonattainment Areas; Determination of Attainment of the Fine Particle Standards'' (FRL No. 8985–2) received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009; to the Committee on Environment and Public Works.

EC–3914. 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 Implementation Plans; Georgia: Revisions to State Implementation Plan'' (FRL No. 8984–7) received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009; to the Committee on Environment and Public Works.

EC–3915. 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 Implementation and Designation of Areas for Air Quality Implementation Plans; Tennessee; Clean Air Interstate Rule'' (FRL No. 8984–6) received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009; to the Committee on Environment and Public Works.

EC–3916. 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 ''Effluent Limitations Guidelines and Standards for the Construction and Development Point Source Category'' (FRL No. 9086–4) received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009; to the Committee on Environment and Public Works.

EC–3917. 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 ''Finding Failure to Submit State Implementation Plans Required for the 1997 Particulate Matter Less Than 2.5 Micrometer (PM2.5) National Ambient Air Quality Standards (NAAQS)'' (FRL No. 8985–6) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3918. 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 ''Prevention of Significant Deterioration (PSD) and Nonattainment New Source Review (NSR): Inclusion of Fugitive Emissions; Interim Final Rule; Stay'' (FRL No. 9089–4) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3919. 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 ''Determinations of Attainment of the One-Hour and Eight-Hour Ozone Standards for Various Ozone Nonattainment Areas in New Jersey and Upstate New York'' (FRL No. 9088–8) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3920. 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 of Section 112(1) Authority for Hazardous Air Pollutants; Equivalency by Permit Provisions; National Emission Standards for Hazardous Air Pollutants; Plywood and Composite Wood Products'' (FRL No. 9089–2) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3921. 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 Implementation Plans and Designation of Areas for Air Quality Planning Purposes; North Carolina: Redesignation of Great Smoky Mountains National Park 1997 8-Hour Ozone Nonattainment Area to Attainment'' (FRL No. 9089–1) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3922. 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 Implementation Plans; Kentucky; Source-Specific Revision for Avis Rent-A-Car and Budget Rent-A-Car Facilities Located at the Cincinnati/Northern Kentucky International Airport'' (FRL No. 9086–1) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Environment and Public Works.

EC–3923. 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; California; Determination of Attainment of the 1997 8-Hour Ozone Standard'' (FRL No. 9086–7) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Environment and Public Works.

EC–3924. 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 ''Novaluron; Pesticide Tolerances'' (FRL No. 8799–6) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3925. 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 ''Hexythiazox; Pesticide Tolerances'' (FRL No. 8799–9) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3926. 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 ''Fenpyroximate; Pesticide Tolerances'' (FRL No. 8799–2) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3927. A communication from the Deputy to the Chairman, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled ''Prepaid Assessments'' (RIN 3064–AD51) received in

the Office of the President of the Senate on December 3, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3928. A communication from the Deputy to the Chairman, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled ''Defining Safe Harbor Protection for Treatment by the Federal Deposit Insurance Corporation as Conservator or Receiver of Financial Assets Transferred by an Insured Depository Institution in Connection With a Securitization or Participation'' (RIN 3064–AD53) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3929. A communication from the Chief Counsel of the Fiscal Service, Bureau of Public Debt, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Sale and Issue of Marketable Book-Entry Treasury Bills, Notes, and Bonds; Customer Confirmation Reporting Requirement Threshold Amount'' (31 CFR Part 356) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3930. A communication from the Secretary of Transportation, transmitting, pursuant to law, an annual report relative to the regulatory status of each recommendation on the National Transportation Safety Board's Most Wanted List; to the Committee on Commerce, Science, and Transportation.

EC–3931. A communication from the Secretary, Federal Trade Commission, transmitting, pursuant to law, a report entitled ''Federal Trade Commission Report to Congress on Marketing Violent Entertainment to Children: A Sixth Follow-Up Review of Industry Practices in the Motion Picture, Music Recording and Electronic Game Industries''; to the Committee on Commerce, Science, and Transportation.

EC–3932. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''List of Fisheries for 2010'' (RIN0648–AX65) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3933. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Magnuson-Stevens Fishery Conservation and Management Act Provisions; Fisheries of the Northeastern United States; Extension of Emergency Fishery Closure Due to the Presence of the Toxin that Causes Paralytic Shellfish Poisoning'' (RIN0648–AT48) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3934. A communication from the Acting Director of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Closure of the 2009 Commercial Harvest of Gulf of Mexico Greater Amberjack'' (RIN0648–XP56) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3935. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Sea World December Fireworks, Mission Bay, San Diego, CA'' ((RIN1625–AA00)(Docket No. USG–2009–0319)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3936. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; SR 90 Bridge, Assawoman Bay, Isle of Wight and Ocean City, MD'' ((RIN1625–AA00)(Docket No. USG–2009–0956)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3937. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Fireworks Displays, Potomac River, National Harbor, MD'' ((RIN1625–AA00)(Docket No. USG–2009–0949)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3938. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Blasting and Dredging Operations and Movement of Explosives, Columbia River, Portland to St. Helens, OR'' ((RIN1625–AA00)(Docket No. USG–2009–0946)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3939. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Perdido Regional Host Outer Continental Shelf Platform, Gulf of Mexico'' ((RIN1625–AA00)(Docket No. USG–2008–1051)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3940. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Corporate Party on Hornblower Yacht, Fireworks Display, San Francisco, CA'' ((RIN1625–AA00)(Docket No. USG–2009–0907)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3941. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Regulated Navigation Area; East Rockaway Inlet to Atlantic Beach Bridge, Nassau County, Long Island, NY'' ((RIN1625–AA11)(Docket No. USG–2008–0085)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3942. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Regulated Navigation Areas; Bars Along the Coasts of Oregon and Washington'' ((RIN1625–AA11)(Docket No. USG–2008–1017)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3943. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Regulated Navigation Area; Portsmouth Naval Shipyard, Portsmouth, NH'' ((RIN1625–AA11)(Docket No. USG–2009–0895)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3944. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone and Regulated Navigation Area, Chicago Sanitary and Ship Canal, Romeoville, IL'' ((RIN1625–AA11)(Docket No. USG–2009–0942)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3945. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Safety Zone; Munitions and Explosives of Concern (MEC); Seal Island, ME'' ((RIN1625–AA00)(Docket No. USG–2009–0595)) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3946. 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; Minnesota'' (FRL No. 9087–7) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Environment and Public Works.

EC–3947. 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; Pennsylvania; Clean Air Interstate Rule; NOx SIP Call Rule; Amendments to NOx Control Rules'' (FRL No. 9090–2) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Environment and Public Works.

EC–3948. A communication from the Secretary of the Interior, transmitting, pursuant to law, the annual report for the Department of the Interior's Office of Surface Mining Reclamation and Enforcement for fiscal year 2008; to the Committee on Energy and Natural Resources.

EC–3949. A communication from the General Counsel of the Pension Benefit Guaranty Corporation, transmitting, pursuant to law, a report relative to a nomination in the position of Director of the Pension Benefit Guaranty Corporation; to the Committee on Health, Education, Labor, and Pensions.

EC–3950. A communication from the General Counsel of the U.S. Trade and Development Agency, transmitting, pursuant to law, a report relative to the report of a nomination in the position of Director of the U.S. Trade and Development Agency; to the Committee on Homeland Security and Governmental Affairs.

EC–3951. A communication from the Secretary of Education, transmitting, pursuant to law, a report on the Department's Semiannual Report to Congress on Audit Follow-Up for the period of April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3952. A communication from the Director of Communications and Legislative Affairs, Equal Employment Opportunity Commission, transmitting, pursuant to law, the Commission's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3953. A communication from the Attorney General, Department of Justice, transmitting, pursuant to law, the Attorney General's Semiannual Management Report and

the Semiannual Report of the Inspector General for the period from April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3954. A communication from the Inspector General of the Department of Energy, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3955. A communication from the Secretary of the Department of the Treasury, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report and the Treasury Inspector General for Tax Administration's Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3956. A communication from the Administrator of the National Aeronautics and Space Administration, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3957. A communication from the Acting Administrator of the U.S. Agency for International Development, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3958. A communication from the Chief of the Border Security Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Technical Amendments to List of CBP Preclearance Offices in Foreign Countries: Addition of Halifax, Canada and Shannon, Ireland'' (CPB Dec. 09–45) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3959. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1979); to the Committee on the Judiciary.

EC–3960. A communication from the Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, an annual report relative to the activities and operations of the Public Integrity Section, Criminal Division, and the nationwide federal law enforcement effort against public corruption for 2008; to the Committee on the Judiciary.

EC–3961. A communication from the Deputy General Counsel, Office of Capital Access, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''American Recovery and Reinvestment Act: Loan Program for Systemically Important SBA Secondary Market Broker-Dealers'' (RIN3245–AF95) received in the Office of the President of the Senate on December 2, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3962. A communication from the Deputy General Counsel, Office of Government Contracting, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''Inflationary Adjustment to Acquisition-Related Dollar Thresholds'' (RIN3245–AF74) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3963. A communication from the Director of Regulation Policy and Management, Veterans Health Administration, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled ''Community Residential Care Program'' (RIN2900–AM82) received in the Office of the President of the Senate on December 3, 2009; to the Committee on Veterans' Affairs.

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. BURRIS:

S. 2841. A bill to amend the Internal Revenue Code of 1986 to allow S corporations the deduction for charitable contribution of inventory; to the Committee on Finance.

By Mr. BEGICH:

S. 2842. A bill to amend the Internal Revenue Code of 1986 to deny the deduction for direct to consumer advertising expenses for prescription pharmaceuticals and to provide a deduction for fees paid for the participation of children in certain organizations which promote physical activity; to the Committee on Finance.

By Ms. STABENOW (for herself, Mr. BROWN, Mr. WYDEN, and Mr. NELSON of Florida):

S. 2843. A bill to provide for a program of research, development, demonstration, and commercial application in vehicle technologies at the Department of Energy; to the Committee on Energy and Natural Resources.

By Mr. SCHUMER (for himself, Mr. KYL, Mrs. FEINSTEIN, and Mr. CORNYN):

S. 2844. A bill to amend title 18, United States Code, to improve the terrorist hoax statute; to the Committee on the Judiciary.

By Mr. SCHUMER (for himself, Mr. KYL, Mrs. FEINSTEIN, and Mr. CORNYN):

S. 2845. A bill to amend section 1028 of title 18, United States Code, to prohibit the possession, transfer, or use of fraudulent documents; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mrs. HAGAN (for herself and Mr. BURR):

S. Res. 371. A resolution congratulating Jimmie Johnson and Hendrick Motorsports for winning the 2009 NASCAR Spring Cup Championship; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 144

At the request of Mr. KERRY, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 144, a bill to amend the Internal Revenue Code of 1986 to remove cell phones from listed property under section 280F.

S. 292

At the request of Mr. SPECTER, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 292, a bill to repeal the imposition of withholding on certain payments made to vendors by government entities.

S. 410

At the request of Mrs. LINCOLN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 410, a bill to amend part E of title IV of the Social Security Act to ensure States follow best policies and practices for supporting and retaining foster parents and to require the Secretary of Health and Human Services to award grants to States to improve the empowerment, leadership, support, training, recruitment, and retention of foster care, kinship care, and adoptive parents.

S. 455

At the request of Mr. ROBERTS, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 455, a bill to require the Secretary of the Treasury to mint coins in recognition of 5 United States Army Five-Star Generals, George Marshall, Douglas MacArthur, Dwight Eisenhower, Henry ''Hap'' Arnold, and Omar Bradley, alumni of the United States Army Command and General Staff College, Fort Leavenworth, Kansas, to coincide with the celebration of the 132nd Anniversary of the founding of the United States Army Command and General Staff College.

S. 461

At the request of Mrs. LINCOLN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 461, a bill to amend the Internal Revenue Code of 1986 to extend and modify the railroad track maintenance credit.

S. 633

At the request of Mr. TESTER, the name of the Senator from North Dakota (Mr. CONRAD) was added as a cosponsor of S. 633, a bill to establish a program for tribal colleges and universities within the Department of Health and Human Services and to amend the Native American Programs Act of 1974 to authorize the provision of grants and cooperative agreements to tribal colleges and universities, and for other purposes.

S. 730

At the request of Mr. ENSIGN, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of S. 730, a bill to amend the Harmonized Tariff Schedule of the United States to modify the tariffs on certain footwear, and for other purposes.

S. 760

At the request of Mrs. MCCASKILL, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 760, a bill to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the ''National World War I Memorial''.

S. 761

At the request of Mr. BOND, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 761, a bill to establish the World War I Centennial Commission to ensure a suitable observance of the centennial of World War I, and for other purposes.

S. 1055

At the request of Mrs. BOXER, the name of the Senator from Colorado (Mr. BENNET) was added as a cosponsor of S. 1055, a bill to grant the congressional gold medal, collectively, to the 100th Infantry Battalion and the 442nd Regimental Combat Team, United States Army, in recognition of their dedicated service during World War II.

S. 1147

At the request of Mr. KOHL, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1222

At the request of Mrs. LINCOLN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1222, a bill to amend the Internal Revenue Code of 1986 to extend and expand the benefits for businesses operating in empowerment zones, enterprise communities, or renewal communities, and for other purposes.

S. 1397

At the request of Ms. KLOBUCHAR, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 1397, a bill to authorize the Administrator of the Environmental Protection Agency to award grants for electronic device recycling research, development, and demonstration projects, and for other purposes.

S. 1518

At the request of Mr. BURR, the names of the Senator from Arkansas (Mrs. LINCOLN), the Senator from Nebraska (Mr. JOHANNS) and the Senator from Florida (Mr. LEMIEUX) were added as cosponsors of S. 1518, a bill to amend title 38, United States Code, to furnish hospital care, medical services, and nursing home care to veterans who were stationed at Camp Lejeune, North Carolina, while the water was contaminated at Camp Lejeune.

S. 1580

At the request of Mrs. GILLIBRAND, her name was added as a cosponsor of S. 1580, a bill to amend the Occupational Safety and Health Act of 1970 to expand coverage under the Act, to increase protections for whistleblowers, to increase penalties for certain violators, and for other purposes.

S. 1775

At the request of Mr. BAYH, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1775, a bill to amend the Higher Education Act of 1965 to provide that interest shall not accrue on Federal Direct Loans for members of the Armed Forces on active duty regardless of the date of disbursement.

S. 1933

At the request of Mr. BINGAMAN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 1933, a bill to establish an integrated Federal program that protects, restores, and conserves natural resources by responding to the threats and effects of climate change, and for other purposes.

S. 1939

At the request of Mrs. GILLIBRAND, the names of the Senator from Arkansas (Mrs. LINCOLN) and the Senator from Vermont (Mr. SANDERS) were added as cosponsors of S. 1939, a bill to amend title 38, United States Code, to clarify presumptions relating to the exposure of certain veterans who served in the vicinity of the Republic of Vietnam, and for other purposes.

S. 2097

At the request of Mr. THUNE, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2106

At the request of Mrs. LINCOLN, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 2106, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 225th anniversary of the establishment of the Nation's first law enforcement agency, the United States Marshals Service.

S. 2760

At the request of Mr. UDALL of New Mexico, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 2760, a bill to amend title 38, United States Code, to provide for an increase in the annual amount authorized to be appropriated to the Secretary of Veterans Affairs to carry out comprehensive service programs for homeless veterans.

S. 2796

At the request of Mr. ENZI, the names of the Senator from South Carolina (Mr. GRAHAM) and the Senator from Nevada (Mr. ENSIGN) were added as cosponsors of S. 2796, a bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes.

S. 2837

At the request of Mrs. LINCOLN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 2837, a bill to amend part E of title IV of the Social Security Act to examine and improve the child welfare workforce, and for other purposes.

AMENDMENT NO. 2789

At the request of Mr. COBURN, the names of the Senator from Missouri (Mrs. MCCASKILL) and the Senator from Nevada (Mr. ENSIGN) were added as cosponsors of amendment No. 2789 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2792

At the request of Mr. KAUFMAN, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of amendment No. 2792 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2793

At the request of Mr. DORGAN, the names of the Senator from California (Mrs. BOXER), the Senator from Virginia (Mr. WEBB) and the Senator from Montana (Mr. TESTER) were added as cosponsors of amendment No. 2793 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2795

At the request of Mr. LEAHY, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of amendment No. 2795 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2916

At the request of Mr. UDALL of New Mexico, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of amendment No. 2916 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2923

At the request of Mr. DORGAN, the names of the Senator from Colorado (Mr. BENNET) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of amendment No. 2923 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2924

At the request of Mr. CASEY, the name of the Senator from Colorado (Mr. UDALL) was added as a cosponsor of amendment No. 2924 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2938

At the request of Mrs. GILLIBRAND, the names of the Senator from New Jersey (Mr. LAUTENBERG) and the Senator from California (Mrs. BOXER) were

added as cosponsors of amendment No. 2938 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2939

At the request of Mr. PRYOR, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of amendment No. 2939 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2942

At the request of Mr. JOHANNS, his name was added as a cosponsor of amendment No. 2942 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 371—CONGRATULATING JIMMIE JOHNSON AND HENDRICK MOTORSPORTS FOR WINNING THE 2009 NASCAR SPRING CUP CHAMPIONSHIP

Mrs. HAGAN (for herself and Mr. BURR) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 371

Whereas on November 22, 2009, Hendrick Motorsports driver Jimmie Johnson won the 2009 NASCAR Sprint Cup Championship after finishing in fifth place in the Ford 400 at Homestead-Miami Speedway;

Whereas Jimmie Johnson's victory represents his fourth straight Sprint Cup Championship, a feat that no driver in the 62-year history of NASCAR's premier series had previously been able to accomplish;

Whereas by capturing 4 Sprint Cup Championships in a row, Jimmie Johnson and Hendrick Motorsports have now surpassed the standard set by Cale Yarborough, who previously held the record with 3 consecutive NASCAR Championships between 1976 and 1978;

Whereas since the ''Chase for the Sprint Cup'' format began in 2004, Jimmie Johnson has won 18 of the 60 Chase races that have been run, failing to finish only once;

Whereas Jimmie Johnson won the 2009 NASCAR Sprint Cup Championship by his widest margin yet, holding a 141-point advantage over his Hendrick teammate, Mark Martin;

Whereas since its inception in February 2006, the Jimmie Johnson Foundation has been dedicated to helping children, families, and communities in need across the United States, and has awarded grants to schools throughout the State of North Carolina, including—

(1) Ashley Park Elementary School in Charlotte, North Carolina;

(2) Collinswood Elementary School in Charlotte, North Carolina;

(3) East Iredell Elementary School in Statesville, North Carolina;

(4) J.H. Gunn Elementary School in Charlotte, North Carolina;

(5) Metro School in Charlotte, North Carolina;

(6) R.B. McAllister Elementary School in Concord, North Carolina;

(7) Smithfield Elementary School in Charlotte, North Carolina;

(8) Third Creek Elementary School in Statesville, North Carolina; and

(9) University Meadows Elementary School in Charlotte, North Carolina;

Whereas in 25 years of competition, Hendrick Motorsports has garnered 8 NASCAR Sprint Cup Series championships, 3 NASCAR Camping World Truck Series titles, and 1 NASCAR Nationwide Series crown (formerly known as the NASCAR Busch Series), making it one of the premier organizations in stock-car racing;

Whereas team owner Rick Hendrick is just the second team owner in the modern era of NASCAR to earn more than 180 Cup Series victories;

Whereas under the Hendrick banner, records have been set for both victories and consistency, with 4 consecutive Southern 500 victories (Jeff Gordon), 6 consecutive road course wins (Gordon), the youngest driver to reach 50 career Cup Series triumphs (Gordon), the youngest driver to win a race in the NASCAR Craftsman Truck Series (Ricky Hendrick), the sole driver to win 3 Truck Series championships (Jack Sprague), and the youngest driver to ever win a NASCAR championship (Brian Vickers);

Whereas all Hendrick race cars are constructed start-to-finish at their 100-plus acre complex, and more than 550 engines are built or rebuilt on-site in Concord, North Carolina each year, with the team leasing some of these engines to other NASCAR outfits;

Whereas the stock car industry has a rich heritage in North Carolina, and as the home to numerous race teams, suppliers, and world-class race tracks, North Carolina has a competitive advantage in this industry;

Whereas as the first race team to implement professional pit crews, Hendrick employs on-site fitness trainers and operates a fully equipped gym to assure that all personnel are in shape and ready for race day; and

Whereas more than 500 employees call Hendrick Motorsports home, with day-to-day activities including management of HendrickMotorsports.com and a 15,000 square foot museum and team store, as well as marketing, public relations, sponsor services, licensing, show cars, merchandising, and much more: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates Jimmie Johnson and Hendrick Motorsports for winning the 2009 NASCAR Sprint Cup Championship;

(2) recognizes the achievements of the owner, driver, pit crew, and support staff, whose perseverance and dedication to excellence helped propel the race team to win the championship; and

(3) respectfully requests the Secretary of the Senate to transmit an enrolled copy of this resolution to—

(A) the team owner of Hendrick Motorsports, Rick Hendrick;

(B) the crew chief of the Lowes Race Team, Chad Knaus; and

(C) the driver of the Lowes Race Team, Jimmie Johnson.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2953. Mr. UDALL, of Colorado submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2954. Mr. UDALL, of Colorado (for himself and Mr. UDALL, of New Mexico) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2955. Mr. UDALL, of Colorado (for himself, Mrs. HAGAN, Ms. KLOBUCHAR, Mr. BEGICH, Mr. KAUFMAN, Mr. UDALL, of New Mexico, Mr. KIRK, Mr. KOHL, Mr. FRANKEN, Mr. SPECTER, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2956. Mr. UDALL, of Colorado (for himself, Mr. HARKIN, and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2957. Mr. BENNET (for himself and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2958. Mr. BENNET submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2959. Mr. LEAHY (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2960. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2961. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2962. Mr. NELSON, of Nebraska (for himself, Mr. HATCH, Mr. CASEY, Mr. BROWNBACK, Mr. THUNE, Mr. ENZI, Mr. COBURN, Mr. JOHANNS, Mr. VITTER, Mr. BARRASSO, Mr. WICKER, Mr. BOND, Mr. BENNETT, and Mr. INHOFE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2963. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2964. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2965. Mr. COBURN submitted an amendment intended to be proposed to amendment

SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2966. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2967. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2968. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2969. Mr. COBURN (for himself, Mr. GRASSLEY, Mr. BURR, Mr. VITTER, Mrs. MCCASKILL, and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2970. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2971. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2972. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2973. Mrs. MURRAY (for herself and Ms. STABENOW) submitted an amendment intended to be proposed by her to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2974. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2975. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2976. Mr. CARDIN (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2977. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2978. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2979. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2980. Ms. MIKULSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2981. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2982. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2983. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2984. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2985. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2986. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2987. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2988. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2989. Mr. MENENDEZ (for himself, Mr. SCHUMER, Mr. DODD, Mrs. GILLIBRAND, Mr. KERRY, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2990. Mr. MENENDEZ submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2991. Mr. MENENDEZ (for himself, Mr. ROCKEFELLER, Mr. BINGAMAN, and Mr. DURBIN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2992. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2993. Mr. SCHUMER (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2994. Mr. SCHUMER (for himself, Mr. AKAKA, Mr. BROWN, Mr. LAUTENBERG, Mr. MERKLEY, Ms. CANTWELL, Mr. KERRY, Mr. LEAHY, Mr. MENENDEZ , and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2995. Mr. SCHUMER (for himself and Ms. MIKULSKI) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2996. Mr. KOHL (for himself, Mr. WYDEN, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2997. Ms. KLOBUCHAR (for herself, Mr. BROWN, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2998. Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2999. Ms. SNOWE (for herself, Mr. KERRY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3000. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2953. Mr. UDALL of Colorado submited an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike line 11 on page 1204 and all that follows through line 16 on page 1206, insert the following:

(B) a local government agency, including municipal, county, and regional public health departments;

(C) a national network of community-based organizations;

(D) a State or local nonprofit organization;

(E) an Indian tribe; or

(F) a nonprofit hospital, clinic, or entity involved in health care delivery or health promotion; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to

engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(d) DIVERSITY.—In awarding grants under this section, the Secretary shall ensure, to the extent practicable, that such grants equitably serve racially, economically, and geographically diverse populations and include grants to rural local government agencies or organizations located in, and focused on serving, rural communities.

(e) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan shall focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity, and smoking cessation, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial, ethnic, and geographic disparities, including social determinants of health; and

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SA 2954. Mr. UDALL of Colorado (for himself and Mr. UDALL of New Mexico) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1265, between lines 8 and 9, insert the following:

SEC. 4307. PILOT PROGRAM TO REDUCE THE INCREASING PREVALENCE OF OVERWEIGHT/OBESITY AMONG CHILDREN FROM BIRTH THROUGH 5 YEARS OF AGE.

(a) FINDINGS.—Congress makes the following findings:

(1) Life-long food preferences, eating habits, and activity levels develop early in childhood.

(2) Preschool years are a critical time for determining whether or not an individual will develop obesity later in life.

(3) Aerobic fitness and healthy eating patterns support enhanced behavioral, emotional, and academic performance in school.

(4) Recent studies indicate that children who are overweight at age 5 are more likely to be more overweight at age 9.

(5) Obese preschool children already exhibit signs of cardiovascular disease and diabetes.

(6) According to a 2007 Centers for Disease Control and Prevention study, 12.4 percent of children in the United States ages 2 through 6 are obese.

(7) The 2001 National Household Education Survey found that 74 percent of children in the United States ages 3 through 6 are in some form of non-parental child care, and 56 percent are in center-based child care.

(8) According to a 2009 analysis of child care center licensing regulations, only 12 States have a policy prohibiting or limiting foods of low nutritional value in child care centers, only 8 States require vigorous or moderate physical activity, only one of which has a policy quantifying a required number of minutes of physical activity by day or week, and only 7 States quantify a maximum amount of time for media (television and electronic) each day or week.

(9) In July 2009, the Centers for Disease Control and Prevention released recommended community strategies and measures to prevent obesity in the United States that includes child care specific policy and environmental initiatives to achieve healthy eating and active living among children from birth to 5 years of age.

(10) In September 2009, The Institute of Medicine released findings supporting local governments' ability to play a crucial role in creating environments that make it easier for children to eat healthy diets and remain active.

(11) States should strive to adopt nutrition standards, practices, and policies for childcare centers that are consistent with the 2005 Dietary Guidelines for Americans.

(12) The Child and Adult Care Food Program is a Federal initiative that provides States with grants to provide children and adults in care settings with nutritious meals and snacks.

(13) Childcare centers should serve as settings where children adopt healthy eating habits, have opportunities for age appropriate physical activity, and set screen time limits.

(b) PURPOSES.—It is the purpose of this Act to—

(1) establish a 3-year pilot program in 5 States that will focus on reducing the increasing prevalence of overweight/obesity among children between birth and 5 years of age in child care settings;

(2) enhance the focus of child care centers serving the birth to 5 years of age population on children's healthy development through evidence-based or data-informed policies and practices to improve healthy eating, physical activity, and screen time limits; and

(3) identify emerging and expand existing evidence-based practices and understanding of healthy eating, physical activity, and screen time limits, as appropriate, as well as replicate curricula, interventions, practices, and policy changes that are most effective in promoting nutrition and physical activity among the birth to 5 years of age population in the child care setting.

(c) DEFINITIONS.—In this section:

(1) CHILD CARE CENTER.—The term ''child care center'' means a nonresidential facility that generally provides child care services for fewer than 24 hours per day per child, unless care in excess of 24 hours is due to the nature of the parents' work, and that is certified, registered, or licensed in the State in which it is located.

(2) EARLY LEARNING COUNCIL.—The term ''early learning council'' means an early childhood assembly that is established to advise governors, State legislators, or State agency administrators on how best to meet the needs of young children and their families specifically through improvement of programs and services.

(3) FAMILY CHILD CARE HOME.—The term ''family child care home'' means a private family home where home-based child care is provided for a portion of the day, unless care in excess of 24 hours is due to the nature of the parents' work, and that is certified, registered, or licensed in the State in which it is located.

(4) SCREEN TIME LIMITS.—The term ''screen time limits'' means policies or guidelines, such as those developed by the American Academy of Pediatrics, designed to reduce the daily amount of time that children spend watching or looking at digital monitors or displays, including television sets, computer monitors, or hand-held gaming devices.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) GRANTS.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award 3-year competitive grants to 5 State health departments (or other appropriate State agency administering the Child and Adult Care Food Program or other child care programs) to help reduce and prevent obesity among the birth to 5 year old population of the State in child care centers and family child care homes.

(2) USE OF FUNDS.—State grantees shall use amounts received under a grant under this subsection to—

(A) provide, or enter into contracts to provide, training (that meets the requirements of paragraph (3)) to the staff of national, State, or community-based organizations with networks of child care centers, or a consortium of childcare centers and family child care homes consisting of at least 10 child care centers or family child care homes, for the purpose of implementing evidence-based or data-informed healthy eating and physical activity policies and practices, including curricula and other interventions; and

(B) provide grants to child care centers and family child care homes, whose staff received the training described in subparagraph (A), to implement practice, curricula, and policy changes (that meet the requirements of paragraph (4)) that promote healthy eating and physical activity among the birth to 5 years of age population.

In determining who receives grant funds, a State shall consider, but not be limited to, child care centers and family child care homes that receive funds under the Child and Adult Care Food Program administered by the Department of Agriculture. Preference shall be given to those States that demonstrate collaboration between relevant State entities related to child care and health and with key stakeholders, such as State early learning councils and other community based organizations working with child care centers or family child care homes.

(3) TRAINING REQUIREMENTS.—

(A) IN GENERAL.—Training provided under paragraph (2) shall—

(i) include the provision of information concerning age-appropriate healthy eating and physical activity interventions and curricula for the birth to 5 years of age population in the State involved;

(ii) identify, improve upon, and expand nutrition and physical activity best practices targeted to the birth to 5 years of age population in the State involved and identify strategies for incorporating parental education and other parental involvement; and

(iii) provide instruction on how to appropriately model, direct, and encourage child care staff behavior to apply the best practices and strategies identified under clause (ii).

(B) TRAINING ENTITIES.—A grantee may conduct the training required under this subsection directly, or may provide such training through a contract with—

(i) an appropriate national, State, or community organization with relevant expertise;

(ii) a health care provider or professional organization with relevant expertise;

(iii) a university or research center that employs faculty with relevant expertise; or

(iv) any other entity determined appropriate by the State and approved by the Secretary.

(C) REQUIREMENT OF CONTRACT.—If a grantee elects to provide the training under this subsection through a contract, the grantee shall ensure that a consistent healthy eating and physical activity curriculum is being developed for all child care entities that provide care for 10 or more children throughout the State.

(4) PRACTICE, CURRICULA, AND POLICY CHANGES.—After training is provided as required under paragraph (3), a State grantee shall ensure that the organizations and consortium involved—

(A) implement, in child care settings, evidence-based or data-informed policy changes that promote healthy eating, physical activity, and appropriate screen time limits among the birth to 5 years of age population;

(B) utilize an evidence-based or data-informed healthy eating and physical activity curriculum in child care settings focusing on such birth to 5 age population;

(C) implement programs, activities, and procedures for incorporating parental education and involvement of parents in programs, including disseminating a written parental involvement policy, and coordinating and integrating parental involvement strategies under this section, to the extent feasible and appropriate, with parental involvement strategies under other programs, such as the Head Start program and the Early Head Start Program; and

(D) find innovative ways to remove barriers that exist to providing opportunities for healthy eating and physical activity.

All activities described in this paragraph shall be evidence-based or data-informed and be consistent with the curriculum presented through training activities described in paragraph (3).

(e) GRANTS FOR THE EVALUATION OF PILOT PROGRAMS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award competitive grants to Prevention Research Centers or universities to evaluate the programs carried out with grants under subsection (d), including baseline, process, and outcome measurements.

(f) COORDINATION.—

(1) INTERAGENCY COORDINATION.—To the extent practicable, the Secretary, acting through the Centers for Disease Control and Prevention, shall coordinate activities conducted under this section with activities undertaken by the National Prevention, Health Promotion and Public Health Council established under section 4001. Where possible, such coordination should—

(A) include the sharing of current and emerging best practices concerning healthy eating, physical activity, and screen time limits that have a population-level impact in promoting nutrition and physical activity in child care settings;

(B) promote the effective implementation and sustainability of such programs; and

(C) avoid unnecessary duplication of effort.

(2) PILOT COORDINATION.—The Director of the Centers for Disease Control and Prevention shall designate an individual (directly or through contract) to provide technical assistance to States and pilot centers in the development, implementation, and evaluation of activities and dissemination of information described in subparagraphs (A), (B), and (C) of paragraph (1).

(g) EVALUATION AND REPORTING.—

(1) TECHNICAL ASSISTANCE AND INFORMATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

(A) provide technical assistance to grantees and other entities providing training under a grant under this section; and

(B) disseminate to health departments and trainers under grants under this section information concerning evidence-based or data-informed approaches, including dissemination of existing toolkits, curricula, and existing or emerging best practices that can be expanded or improved upon through a program conducted under this section.

(2) EVALUATION REQUIREMENTS.—With respect to evaluations conducted under subsection (e), the Secretary, acting through the Director of the Center for Disease Control and Prevention, shall ensure that—

(A) evaluation metrics are consistent across all programs funded under this section;

(B) interim outcomes are measured by the number of centers that have implemented policy and environmental strategies that support use of curricula and practices supporting healthy eating, physical activity, and screen time limits;

(C) interim outcomes are measured, to the extent possible, by behavior changes in healthy eating, physical activity, and screen time; and

(D) upon completion of the program, the evaluation shall include an identification of best practices relating to behavior change and reductions in the increasing prevalence of overweight and obesity that could be replicated in other settings.

(3) DISSEMINATION OF INFORMATION.—Upon the conclusion of the programs carried out under this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall disseminate evidence, best practices, and lessons learned from grantees and shall submit to Congress a report concerning the evaluation of such programs, including recommendations as to how lessons learned from such programs can be incorporated into future guidance documents developed and provided by the Director for States and communities funded for nutrition, physical activity, and obesity prevention.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $7,500,000 for each of fiscal years 2011, 2012 and 2013.

SA 2955. Mr. UDALL of Colorado (for himself, Mrs. HAGAN, Ms. KLOBUCHAR, Mr. BEGICH, Mr. KAUFMAN, Mr. UDALL of New Mexico, Mr. KIRK, Mr. KOHL, Mr. FRANKEN, Mr. SPECTER, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1507, after line 19, insert the following:

SEC. 5510. RURAL PHYSICIAN TRAINING GRANTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(1) after the part heading, by inserting the following:

"Subpart I—Medical Training Generally";

and

(2) by inserting at the end the following:

"Subpart II—Training in Underserved Communities

"SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program to make grants to eligible entities for the purposes of—

''(1) assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities;

''(2) providing rural-focused training and experience; and

''(3) increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities.

''(b) ELIGIBLE ENTITIES.—In order to be eligible to receive a grant under this section, an entity shall—

''(1) be a school of allopathic or osteopathic medicine accredited by a nationally recognized accrediting agency or association approved by the Secretary for this purpose, or any combination or consortium of such schools; and

''(2) submit an application to the Secretary at such time, in such form, and containing such information as the Secretary may require, including a certification that such entity—

''(A) will use amounts provided to the institution to—

''(i) establish and carry out a Rural Physician Training Program described in subsection (d);

''(ii) improve an existing rural-focused training program to meet the requirements described in subsection (d) and carry out such program; or

''(iii) expand and carry out an existing rural-focused training program that meets the requirements described in subsection (d); and

''(B) employs, or will employ within a timeframe sufficient to implement the Program (as described by a timetable and supporting documentation in the application of the eligible entity), faculty with experience or training in rural medicine or with experience in training rural physicians.

''(c) PRIORITY.—In awarding grant funds under this section, the Secretary shall give priority to eligible entities that—

''(1) demonstrate a record of successfully training students, as determined by the Secretary, who practice medicine in underserved rural communities;

''(2) demonstrate that an existing academic program of the eligible entity produces a high percentage, as determined by the Secretary, of graduates from such program who practice medicine in underserved rural communities;

''(3) demonstrate rural community institutional partnerships, through such mechanisms as matching or contributory funding, documented in-kind services for implementation, or existence of training partners with interprofessional expertise (such as dental, vision, or mental health services) in community health center training locations or other similar facilities; or

''(4) submit, as part of the application of the entity under subsection (b), a plan for the long-term tracking of where the graduates of such entity are practicing medicine.

''(d) USE OF FUNDS.—

''(1) ESTABLISHMENT.—An eligible entity receiving a grant under this section shall use the funds made available under such grant to—

''(A) establish and carry out a 'Rural Physician Training Program' (referred to in this section as the 'Program');

''(B) improve an existing rural-focused training program to meet the Program requirements described in this subsection and carry out such program; or

''(C) expand and carry out an existing rural-focused training program that meets the Program requirements described in this subsection.

''(2) STRUCTURE OF PROGRAM.—An eligible entity shall—

''(A) enroll no fewer than 10 students per class year into the Program; and

''(B) develop criteria for admission to the Program that gives priority to students—

''(i) who have originated from or lived for a period of 2 or more years in an underserved rural community; and

''(ii) who express a commitment to practice medicine in an underserved rural community.

''(3) CURRICULA.—The Program shall require students to enroll in didactic coursework and clinical experience particularly applicable to medical practice in underserved rural communities, including—

''(A) clinical rotations in underserved rural communities, and in specialties including family medicine, internal medicine, pediatrics, surgery, psychiatry, and emergency medicine;

''(B) in addition to core school curricula, additional coursework or training experiences focused on medical issues prevalent in underserved rural communities, including in areas such as trauma, obstetrics, ultrasound, oral health, and behavioral health; and

''(C) any coursework or clinical experience that—

''(i) may be developed as a result of the Symposium described in subsection (f); or

''(ii) the Secretary finds appropriate.

''(4) RESIDENCY PLACEMENT ASSISTANCE.—Where available, the Program shall assist all students of the Program in obtaining clinical training experiences in locations with postgraduate programs offering residency training opportunities in underserved rural communities, or in local residency training programs that support and train physicians to practice in underserved rural communities, as well as assist all students of the Program in obtaining postgraduate residency training in such programs.

''(5) PROGRAM STUDENT COHORT SUPPORT.—The Program shall provide and require all students of the Program to participate in social, educational, and other group activities designed to further develop, maintain, and reinforce the original commitment of such students to practice in an underserved rural community.

''(e) ANNUAL REPORTING REQUIREMENT.—On an annual basis, an eligible entity receiving a grant under this section shall submit a report to the Secretary on—

''(1) the overall success of the Program established by the entity, based on criteria the Secretary determines appropriate;

''(2) the number of students participating in the Program;

''(3) the number of graduating students who participated in the Program;

''(4) the residency program selection of graduating students who participated in the Program;

''(5) the number of graduates who participated in the Program who are practicing in underserved rural communities not less than one year after completing residency training; and

''(6) the number of graduates who participated in the Program who are not practicing in underserved rural communities not less than one year after completing residency training.

''(f) RURAL TRAINING PROGRAM SYMPOSIUM.—

''(1) PURPOSES OF SYMPOSIUM.—To assist the Secretary in carrying out the Program and making grant determinations under this section, the Secretary shall convene a Rural Training Program Symposium (referred to in this section as the 'Symposium') to—

''(A) develop best practices that may be incorporated into consideration of applications under subsection (b); and

''(B) establish a network of allopathic and osteopathic medical schools that have developed or will develop rural training programs in accordance with subsection (d).

''(2) COMPOSITION.—The Symposium shall include—

''(A) representatives from eligible entities with existing rural training programs;

''(B) representatives from all eligible entities interested in developing the Program;

''(C) representatives from area health education centers;

''(D) representatives from the Health Resources and Services Administration; and

''(E) any other experts or individuals with experience in practicing medicine in underserved rural communities the Secretary determines appropriate.

''(g) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall by regulation define 'underserved rural community' for purposes of this section.

''(h) SUPPLEMENT NOT SUPPLANT.—Any eligible entity receiving funds under this section shall use such funds to supplement, not supplant, any other Federal, State, and local funds that would otherwise be expended by such entity to carry out the activities described in this section.

''(i) MAINTENANCE OF EFFORT.—With respect to activities for which funds awarded under this section are to be expended, the entity shall agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives a grant under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

''(1) to carry out this section (other than subsection (f))—

''(A) $4,000,000 for fiscal year 2010;

''(B) $8,000,000 for fiscal year 2011;

''(C) $12,000,000 for fiscal year 2012;

''(D) $16,000,000 for fiscal year 2013; and

''(2) to carry out subsection (f), such sums as may be necessary.''.

SA 2956. Mr. UDALL of Colorado (for himself, Mr. HARKIN, and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590 to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for the purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

Subtitle F—Physical Activity Guidelines and Foundation

PART I—PHYSICAL ACTIVITY GUIDELINES

SEC. 4501. ESTABLISHMENT OF PHYSICAL ACTIVITY GUIDELINES.

(a) REPORT.—

(1) IN GENERAL.—At least every 5 years, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall publish a report entitled ''Physical Activity Guidelines for Americans''. Each such report shall contain physical activity information and guidelines for the general public, and shall be promoted by each Federal agency in carrying out any Federal health program.

(2) BASIS OF GUIDELINES.—The information and guidelines contained in each report required under paragraph (1) shall be based on the preponderance of the scientific and medical knowledge which is current at the time the report is prepared.

(b) APPROVAL BY SECRETARY.—

(1) REVIEW.—Any Federal agency that proposes to issue any physical activity guidance for the general population or identified population subgroups shall submit the text of such guidance to the Secretary for a 60-day review period.

(2) BASIS OF REVIEW.—

(A) IN GENERAL.—During the 60-day review period established in paragraph (1), the Secretary shall review and approve or disapprove such guidance to assure that the guidance either is consistent with the ''Physical Activity Guidelines for Americans'' or that the guidance is based on medical or new scientific knowledge which is determined to be valid by the Secretary. If after such 60-day review period the Secretary has not notified the proposing agency that such guidance has been disapproved, then such guidance may be issued by the agency. If the Secretary disapproves such guidance, it shall be returned to the agency. If the Secretary finds that such guidance is inconsistent with the ''Physical Activity Guidelines for Americans'' and so notifies the proposing agency, such agency shall follow the procedures set forth in this subsection before disseminating such proposal to the public in final form. If after such 60-day period, the Secretary disapproves such guidance as inconsistent with the ''Physical Activity Guidelines for Americans'' the proposing agency shall—

(i) publish a notice in the Federal Register of the availability of the full text of the proposal and the preamble of such proposal which shall explain the basis and purpose for the proposed physical activity guidance;

(ii) provide in such notice for a public comment period of 30 days; and

(iii) make available for public inspection and copying during normal business hours any comment received by the agency during such comment period.

(B) REVIEW OF COMMENTS.—After review of comments received during the comment period, the Secretary may approve for dissemination by the proposing agency a final version of such physical activity guidance along with an explanation of the basis and purpose for the final guidance which addresses significant and substantive comments as determined by the proposing agency.

(C) ANNOUNCEMENT.—Any such final physical activity guidance to be disseminated under subparagraph (B) shall be announced in a notice published in the Federal Register, before public dissemination along with an address where copies may be obtained.

(D) NOTIFICATION OF DISAPPROVAL.—If after the 30-day period for comment as provided under subparagraph (A)(ii), the Secretary disapproves a proposed physical activity guidance, the Secretary shall notify the Federal agency submitting such guidance of such disapproval, and such guidance may not be issued, except as provided in subparagraph (E).

(E) REVIEW OF DISAPPROVAL.—If a proposed physical activity guidance is disapproved by the Secretary under subparagraph (D), the Federal agency proposing such guidance

may, within 15 days after receiving notification of such disapproval under subparagraph (D), request the Secretary to review such disapproval. Within 15 days after receiving a request for such a review, the Secretary shall conduct such review. If, pursuant to such review, the Secretary approves such proposed physical activity guidance, such guidance may be issued by the Federal agency.

(3) DEFINITIONS.—In this subsection:

(A) The term ''physical activity guidance for the general population'' does not include any rule or regulation issued by a Federal agency.

(B) The term ''identified population subgroups'' shall include, but not be limited to, groups based on factors such as age, sex, race, or physical disability.

(c) EXISTING AUTHORITY NOT AFFECTED.—This section does not place any limitations on—

(1) the conduct or support of any scientific or medical research by any Federal agency; or

(2) the presentation of any scientific or medical findings or the exchange or review of scientific or medical information by any Federal agency.

PART II—NATIONAL FOUNDATION ON PHYSICAL FITNESS AND SPORTS

SEC. 4511. ESTABLISHMENT AND PURPOSE OF FOUNDATION.

(a) ESTABLISHMENT.—There is established the National Foundation on Physical Fitness and Sports (hereinafter in this part referred to as the ''Foundation''). The Foundation is a charitable and nonprofit corporation and is not an agency or establishment of the United States.

(b) PURPOSES.—The purposes of the Foundation are—

(1) in conjunction with the President's Council on Physical Fitness and Sports, to develop a list and description of programs, events and other activities which would further the goals outlined in Executive Order 12345 and with respect to which combined private and governmental efforts would be beneficial; and

(2) to encourage and promote the participation by private organizations in the activities referred to in subsection (b)(1) and to encourage and promote private gifts of money and other property to support those activities.

(c) DISPOSITION OF MONEY AND PROPERTY.—At least annually the Foundation shall transfer, after the deduction of the administrative expenses of the Foundation, the balance of any contributions received for the activities referred to in subsection (b), to the United States Public Health Service Gift Fund pursuant to section 2701 of the Public Health Service Act (42 U.S.C. 300aaa) for expenditure pursuant to the provisions of that section and consistent with the purposes for which the funds were donated.

SEC. 4512. BOARD OF DIRECTORS OF THE FOUNDATION.

(a) ESTABLISHMENT AND MEMBERSHIP.—The Foundation shall have a governing Board of Directors (hereinafter referred to in this part as the ''Board''), which shall consist of 9 members each of whom shall be a United States citizen and—

(1) 3 of whom must be knowledgeable or experienced in one or more fields directly connected with physical fitness, sports, or the relationship between health status and physical exercise; and

(2) 6 of whom must be leaders in the private sector with a strong interest in physical fitness, sports, or the relationship between health status and physical exercise.

The membership of the Board, to the extent practicable, shall represent diverse professional specialties relating to the achievement of physical fitness through regular participation in programs of exercise, sports, and similar activities. The Assistant Secretary for Health, the Executive Director of the President's Council on Physical Fitness and Sports, the Director for the National Center for Chronic Disease Prevention and Health Promotion, the Director of the National Heart, Lung, and Blood Institute, and the Director for the Centers for Disease Control and Prevention shall be ex officio, nonvoting members of the Board. Appointment to the Board or its staff shall not constitute employment by, or the holding of an office of, the United States for the purposes of any Federal employment or other law.

(b) APPOINTMENTS.—Within 90 days from the date of enactment of this Act, the members of the Board will be appointed. Three members of the Board will be appointed by the Secretary (hereinafter referred to in this part as the ''Secretary''), 2 by the majority leader of the Senate, 1 by the minority leader of the Senate, 2 by the Speaker of the House of Representatives, 1 by the minority leader of the House of Representatives.

(c) TERMS.—The members of the Board shall serve for a term of 6 years. A vacancy on the Board shall be filled within 60 days of the vacancy in the same manner in which the original appointment was made and shall be for the balance of the term of the individual who was replaced. No individual may serve more than 2 consecutive terms as a member.

(d) CHAIRMAN.—The Chairman shall be elected by the Board from its members for a 2-year term and will not be limited in terms or service.

(e) QUORUM.—A majority of the current membership of the Board shall constitute a quorum for the transaction of business.

(f) MEETINGS.—The Board shall meet at the call of the Chairman at least once a year. If a member misses 3 consecutive regularly scheduled meetings, that member may be removed from the Board and the vacancy filled in accordance with subsection (c).

(g) REIMBURSEMENT OF EXPENSES.—Members of the Board shall serve without pay, but may be reimbursed for the actual and necessary traveling and subsistence expenses incurred by them in the performance of the duties of the Foundation, subject to the same limitations on reimbursement that are imposed upon employees of Federal agencies.

(h) LIMITATIONS.—The following limitations apply with respect to the appointment of officers and employees of the Foundation:

(1) Officers and employees may not be appointed until the Foundation has sufficient funds to pay them for their service. No individual so appointed may receive pay in excess of the annual rate of basic pay in effect for Executive Level V in the Federal service.

(2) The first officer or employee appointed by the Board shall be the Secretary of the Board who shall serve, at the direction of the Board, as its chief operating officer and shall be knowledgeable and experienced in matters relating to physical fitness and sports.

(3) No Public Health Service employee nor the spouse or dependent relative of such an employee may serve as an officer or member of the Board of Directors or as an employee of the Foundation.

(4) Any individual who is an officer, employee, or member of the Board of the Foundation may not (in accordance with the policies developed under subsection (i)) personally or substantially participate in the consideration or determination by the Foundation of any matter that would directly or predictably affect any financial interest of the individual or a relative (as such term is defined in section 109(16) of the Ethics in Government Act, 1978) of the individual, of any business organization, or other entity, or of which the individual is an officer or employee, is negotiating for employment, or in which the individual has any other financial interest.

(i) GENERAL POWERS.—The Board may complete the organization of the Foundation by—

(1) appointing officers and employees;

(2) adopting a constitution and bylaws consistent with the purposes of the Foundation and the provision of this part; and

(3) undertaking such other acts as may be necessary to carry out the provisions of this part.

In establishing bylaws under this subsection, the Board shall provide for policies with regard to financial conflicts of interest and ethical standards for the acceptance, solicitation and disposition of donations and grants to the Foundation.

SEC. 4513. RIGHTS AND OBLIGATIONS OF THE FOUNDATION.

(a) IN GENERAL.—The Foundation—

(1) shall have perpetual succession;

(2) may conduct business throughout the several States, territories, and possessions of the United States;

(3) shall have its principal offices in or near the District of Columbia; and

(4) shall at all times maintain a designated agent authorized to accept service of process for the Foundation.

The serving of notice to, or service of process upon, the agent required under paragraph (4), or mailed to the business address of such agent, shall be deemed as service upon or notice to the Foundation.

(b) SEAL.—The Foundation shall have an official seal selected by the Board which shall be judicially noticed.

(c) POWERS.—To carry out its purposes under section 4511, and subject to the specific provisions thereof, the Foundation shall have the usual powers of a corporation acting as a trustee in the District of Columbia, including the power—

(1) except as otherwise provided herein, to accept, receive, solicit, hold, administer and use any gift, devise, or bequest, either absolutely or in trust, of real or personal property or any income therefrom or other interest therein;

(2) to acquire by purchase or exchange any real or personal property or interest therein;

(3) unless otherwise required by the instrument of transfer, to sell, donate, lease, invest, reinvest, retain or otherwise dispose of any property or income therefrom;

(4) to sue and be sued, and complain and defend itself in any court of competent jurisdiction, except for gross negligence;

(5) to enter into contracts or other arrangements with public agencies and private organizations and persons and to make such payments as may be necessary to carry out its functions; and

(6) to do any and all acts necessary and proper to carry out the purposes of the Foundation.

For purposes of this part, an interest in real property shall be treated as including easements or other rights for preservation, conservation, protection, or enhancement by and for the public of natural, scenic, historic, scientific, educational inspirational or recreational resources. A gift, devise, or bequest may be accepted by the Foundation even though it is encumbered, restricted, or subject to beneficial interests of private persons if any current or future interest therein is for the benefit of the Foundation.

SEC. 4514. PROTECTION AND USES OF TRADEMARKS AND TRADE NAMES.

(a) PROTECTION.—Without the consent of the Foundation in conjunction with the President's Council on Physical Fitness and Sports, any person who uses for the purpose

of trade, uses to induce the sale of any goods or services, or uses to promote any theatrical exhibition, athletic performance or competition—

(1) the official seal of the President's Council on Physical Fitness and Sports consisting of the eagle holding an olive branch and arrows with shield breast encircled by name ''President's Council on Physical Fitness and Sports'' and consisting, depending upon placement, of diagonal stripes;

(2) the official seal of the Foundation; or

(3) any trademark, trade name, sign, symbol, or insignia falsely representing association with or authorization by the President's Council on Physical Fitness and Sports or the Foundation;

shall be subject in a civil action by the Foundation for the remedies provided in the Act of July 9, 1946 (60 Stat. 427; popularly known as the Trademark Act of 1946).

(b) USES.—The Foundation, in conjunction with the President's Council on Physical Fitness and Sports, may authorize contributors and suppliers of goods or services to use the trade name or the President's Council on Physical Fitness and Sports and the Foundation as well as any trademark, seal, symbol, insignia, or emblem of the President's Council on Physical Fitness and Sports or the Foundation in advertising that the contributors, goods, or services when donated, supplied, or furnished to or for the use of, or approved, selected, or used by the President's Council on Physical Fitness and Sports or the Foundation.

SEC. 4515. VOLUNTEER STATUS.

The Foundation may accept, without regard to the civil service classification laws, rules, or regulations, the services of volunteers in the performance of the functions authorized herein, in the manner provided for under section 7(c) of the Fish and Wildlife Act of 1956 (16 U.S.C. 742f(c)).

SEC. 4516. AUDIT, REPORT REQUIREMENTS, AND PETITION OF ATTORNEY GENERAL FOR EQUITABLE RELIEF.

(a) AUDITS.—For purposes of the Act entitled ''An Act for audit of accounts of private corporations established under Federal law'', approved August 30, 1964 (Public Law 88–504, 36 U.S.C. 1101–1103), the Foundation shall be treated as a private corporation under Federal law. The Inspector General of the Department of Health and Human Services and the Comptroller General of the United States shall have access to the financial and other records of the Foundation, upon reasonable notice.

(b) REPORT.—The Foundation shall, as soon as practicable after the end of each fiscal year, transmit to the Secretary of Health and Human Services and to Congress a report of its proceedings and activities during such year, including a full and complete statement of its receipts, expenditures, and investments.

(c) RELIEF WITH RESPECT TO CERTAIN FOUNDATION ACTS OR FAILURE TO ACT.—If the Foundation—

(1) engages in, or threatens to engage in, any act, practice or policy that is inconsistent with its purposes set forth in section 4511(b); or

(2) refuses, fails, or neglects to discharge its obligations under this part, or threaten to do so;

the Attorney General of the United States may petition in the United States District Court for the District of Columbia for such equitable relief as may be necessary or appropriate.

SEC. 4517. AUTHORIZATION OF APPROPRIATIONS.

For fiscal year 2010, there are authorized to be appropriated such sums as may be necessary, to be made available to the Foundation for organizational costs.

SA 2957. Mr. BENNET (for himself and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of section 4101, insert the following:

(c) AMENDMENTS TO SCHOOL-BASED HEALTH CENTERS PROGRAM.—Section 399Z-1 of the Public Health Service Act, as added by subsection (b), is amended—

(1) in subsection (f)(1)(A)(iii), by inserting '', including programs to promote healthy, active lifestyles and wellness for students'' after ''programs'';

(2) by redesignating subsection (l) as subsection (m); and

(3) by inserting after subsection (k) the following:

''(l) REGULATIONS REGARDING REIMBURSEMENT FOR HEALTH SERVICES.—The Secretary shall issue regulations regarding the reimbursement for health services provided by SBHCs to individuals eligible to receive such services through the program under this section, including reimbursement under any insurance policy or any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act).''.

SA 2958. Mr. BENNET submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VII, insert the following:

Subtitle C—Rural Health Access and Improvement

SEC. 7201. GRANTS TO PROMOTE HOSPITAL HEALTH INFORMATION TECHNOLOGY.

Section 3013 of the Public Health Service Act (42 U.S.C. 300jj–33) is amended by adding at the end the following:

''(j) PRIORITY.—In awarding a grant under this section, the Secretary shall give priority to qualified State-designated entities that are critical access hospitals, as defined in section 1861(mm) of the Social Security Act.''.

SEC. 7202. EXPANDED PARTICIPATION IN SECTION 340B PROGRAM.

Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), as amended by section 7101(a), is further amended by adding at the end the following:

''(P) An entity that is a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act.''.

SEC. 7203. GAO STUDY AND REPORT ON DISPENSING FEES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of the cost in each State of dispensing prescription drugs under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), which shall consider—

(1) any reasonable costs associated with pharmacists—

(A) checking for information regarding Medicaid coverage of individuals; and

(B) performing necessary clinical review and quality assurance activities, such as—

(i) activities to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care among physicians, pharmacists, and patients;

(ii) activities associated with specific drugs or groups of drugs, including potential and actual severe adverse reactions to drugs, including education on therapeutic appropriateness, over-utilization and under-utilization of drugs, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse; and

(iii) any other clinical review and quality assurance activities required under Federal or State law;

(2) the costs incurred by a pharmacy that are associated with—

(A) the measurement or mixing of a drug covered by Medicaid;

(B) filling the container for such a drug;

(C) physically transferring the prescription to the patient, including any costs of delivering the medication to the home of such patient;

(D) special packaging of drugs;

(E) overhead costs of the pharmacy, or the section of the facility that is devoted to a pharmacy, and maintenance of the pharmacy or section of the facility (including the equipment necessary to operate such pharmacy or such section and the salaries of pharmacists and other pharmacy workers);

(F) geographic factors that impact operational costs;

(G) compounding such prescription if necessary; and

(H) uncollectability of Medicaid prescription copayments;

(3) the variation in costs described in paragraph (2) based on—

(A) whether a product dispensed is a rural or urban pharmacy;

(B) whether the product dispensed is a specialty pharmacy product; and

(C) whether the pharmacy is located in, or contracts with, a long-term care facility; and

(4) the increase in dispensing fees, including the costs described in paragraphs (1), (2), and (3), that would be sufficient to create an incentive for a pharmacist to promote the use of generic medications.

(b) REPORT.—Not later than December 1, 2010, the Comptroller General of the United States shall submit to the Secretary of Health and Human Services and to each State a report describing the study conducted under subsection (a). The report shall include—

(1) the average cost in each State of dispensing a prescription drug under Medicaid;

(2) the findings of the study conducted under subsection (a) with respect to—

(A) the variation in costs studied under subparagraphs (A) and (B) of paragraph (3) of such subsection; and

(B) the increase in dispensing fees described in paragraph (4) of such subsection.

(c) USE OF STUDY.—Each State shall use the report described in subsection (b) to assess the adequacy of Medicaid pharmacy dispensing fees. The Secretary of Health and Human Services shall use such report to approve State plan amendments for States that submit such amendments for the purposes of increasing Medicaid pharmacy dispensing fees.

SEC. 7204. STATE OFFICES OF RURAL HEALTH.

Section 338J of the Public Health Service Act (42 U.S.C. 254r) is amended by striking subsection (k).

SA 2959. Mr. LEAHY (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

SEC. 4403. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) IN GENERAL.—Section 224(o)(1) of the Public Health Service Act (42 U.S.C. 233(o)(1)) is amended by inserting after ''to an individual'' the following: '', or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic,''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SA 2960. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. RECOGNITION OF CERTIFIED DIABETES EDUCATORS AS CERTIFIED PROVIDERS FOR PURPOSES OF MEDICARE DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.

(a) IN GENERAL.—Section 1861(qq) of the Social Security Act (42 U.S.C. 1395x(qq)) is amended—

(1) in paragraph (1), by inserting ''or by a certified diabetes educator (as defined in paragraph (3))'' after ''paragraph (2)(B)''; and

(2) by adding at the end the following new paragraphs:

''(3) For purposes of paragraph (1), the term 'certified diabetes educator' means an individual who—

''(A) is licensed or registered by the State in which the services are performed as a health care professional;

''(B) specializes in teaching individuals with diabetes to develop the necessary skills and knowledge to manage the individual's diabetic condition; and

''(C) is certified as a diabetes educator by a recognized certifying body (as defined in paragraph (4)).

''(4)(A) For purposes of paragraph (3)(C), the term 'recognized certifying body' means—

''(i) the National Certification Board for Diabetes Educators, or

''(ii) a certifying body for diabetes educators, which is recognized by the Secretary as authorized to grant certification of diabetes educators for purposes of this subsection pursuant to standards established by the Secretary, if the Secretary determines such Board or body, respectively, meets the requirement of subparagraph (B).

''(B) The National Certification Board for Diabetes Educators or a certifying body for diabetes educators meets the requirement of this subparagraph, with respect to the certification of an individual, if the Board or body, respectively, is incorporated and registered to do business in the United States and requires as a condition of such certification each of the following:

''(i) The individual has a qualifying credential in a specified health care profession.

''(ii) The individual has professional practice experience in diabetes self-management training that includes a minimum number of hours and years of experience in such training.

''(iii) The individual has successfully completed a national certification examination offered by such entity.

''(iv) The individual periodically renews certification status following initial certification.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to diabetes outpatient self-management training services furnished on or after the first day of the first calendar year that is at least 6 months after the date of the enactment of this Act.

SA 2961. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1925, between lines 14 and 15, insert the following:

Subtitle C—Provisions Relating to Generic Drugs

SEC. 7201. LABELING CHANGES.

Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended by adding at the end the following:

''(10)(A) If the proposed labeling of a drug that is the subject of an application under this subsection differs from the listed drug due to a labeling revision described under clause (i), the drug that is the subject of such application shall, notwithstanding any other provision of this Act, be eligible for approval and shall not be considered misbranded under section 502 if—

''(i) the application is otherwise eligible for approval under this subsection but for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(B)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration;

''(ii) the labeling revision described under clause (i) does not include a change to the 'Warnings' section of the labeling;

''(iii) the sponsor of the application under this subsection agrees to submit revised labeling of the drug that is the subject of such application not later than 60 days after the notification of any changes to such labeling required by the Secretary; and

''(iv) such application otherwise meets the applicable requirements for approval under this subsection.

''(B) If, after a labeling revision described in subparagraph (A)(i), the Secretary determines that the continued presence in interstate commerce of the labeling of the listed drug (as in effect before the revision described in subparagraph (A)(i)) adversely impacts the safe use of the drug, no application under this subsection shall be eligible for approval with such labeling.''.

SA 2962. Mr. NELSON of Nebraska (for himself, Mr. HATCH, Mr. CASEY, Mr. BROWNBACK, Mr. THUNE, Mr. ENZI, Mr. COBURN, Mr. JOHANNS, Mr. VITTER, Mr. BARRASSO, Mr. WICKER, Mr. BOND, Mr. BENNETT, and Mr. INHOFE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Beginning on page 116, strike line 15 and all that follows through line 15 on page 123, and insert the following:

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), nothing in this Act (or any amendment made by this Act) shall be construed to require any health plan to provide coverage of abortion services or to allow the Secretary or any other person or entity implementing this Act (or amendment) to require coverage of such services.

(2) COMMUNITY HEALTH INSURANCE OPTION.—The Secretary may not provide coverage of abortion services in the community health insurance option established under section 1323, except in the case where use of funds authorized or appropriated by this Act is permitted for such services under subsection (b)(1).

(3) NO DISCRIMINATION ON THE BASIS OF PROVISION OF ABORTION.—No Exchange participating health benefits plan may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(b) LIMITATION ON ABORTION FUNDING.—

(1) IN GENERAL.—No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

(2) OPTION TO PURCHASE SEPARATE SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall be construed as prohibiting any non-Federal entity (including an individual or a State or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act; and

(B) such coverage or plan is not purchased using—

(i) individual premium payments required for a qualified health plan offered through the Exchange towards which a credit is applied under section 36B of the Internal Revenue Code of 1986; or

(ii) other non-Federal funds required to receive a Federal payment, including a State's or locality's contribution of Medicaid matching funds.

(3) OPTION TO OFFER SUPPLEMENTAL COVERAGE OR PLAN.—Nothing in this subsection shall restrict any non-Federal health insurance issuer offering a qualified health plan from offering separate supplemental coverage for abortions for which funding is prohibited under this subsection, or a plan that includes such abortions, so long as—

(A) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated by this Act;

(B) administrative costs and all services offered through such supplemental coverage or plan are paid for using only premiums collected for such coverage or plan; and

(C) any such non-Federal health insurance issuer that offers a qualified health plan through the Exchange that includes coverage for abortions for which funding is prohibited under this subsection also offers a qualified health plan through the Exchange that is identical in every respect except that it does not cover abortions for which funding is prohibited under this subsection.

SA 2963. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

SEC. 90___. OPT-OUT OF TAXES AND FEES IMPOSED ON STATES AND INDIVIDUALS.

(a) IN GENERAL.—An individual or State may elect to opt out of any fee or tax imposed or increased under this Act or any amendment made by this Act, including the application of—

(1) the amendments made by section 9003 (relating to distributions for medicine qualified only if for prescribed drug or insulin), and

(2) the amendments made by section 9013 (relating to the modification of itemized deduction for medical expenses).

(b) PROCESS FOR ELECTION; NOTIFICATION OF OPT-OUT.—

(1) IN GENERAL.—Any election under subsection (a) shall be made by filing a statement (on line, by mail, or in such other manner as specified by the appropriate Secretary)—

(A) in the case of any tax provision, with the Secretary of the Treasury, and

(B) in the case of any other provision, with the Secretary of Health and Human Services. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall establish a form that may be used for making an election under subsection (a) and shall make such form available on the Internet.

(2) NOTIFICATION.—

(A) IN GENERAL.—Not later than 1 month after the date of the enactment of this Act, the Secretary of the Treasury, together with the Secretary of Health and Human Services, shall mail a notice to each individual who may make an election under subsection (a).

(B) CONTENT.—The notification under subparagraph (A) shall—

(i) state that this Act will create government-run health care exchanges and program that will be paid for in part with higher taxes and other fees, and

(ii) a form that can be used for opting out of such fees and taxes.

(3) REVOCATION.—An individual may revoke an election make under subsection (a) at any time in a manner similar to the manner in which the election is made under paragraph (1).

(c) RESPONSIBILITY REQUIREMENTS TREATED AS TAX PROVISIONS.—For purposes of this section, amounts imposed under sections 5000A and 4980H of the Internal Revenue Code of 1986, as added by this Act, shall be treated as taxes.

SA 2964. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 17, strike line 11 through line 14.

On page 396, between lines 8 and 9, insert the following:

SEC. 1563. ENSURING THAT GOVERNMENT HEALTH CARE RATIONING DOES NOT HARM, INJURE, OR DENY MEDICALLY NECESSARY CARE.

Notwithstanding any other provision of law—

(1) no individual may be denied health care based on age or life expectancy by any Federal health program, the community health insurance option established under section 1323, or any Exchange established under this Act; and

(2) no entity of the Federal Government may develop Quality-Adjusted Life Year measures or other similarly designed government formulas for limiting access to treatment.

Strike section 3403.

Strike section 4105.

On page 1680, between lines 20 and 21, insert the following:

''(2) PROHIBITION.—The findings of the Institute are prohibited from being used by any government entity for payment, coverage, or treatment decisions. Nothing in the preceding sentence shall limit a physician or other health care provider from using Institute reports and recommendations when making decisions about the best treatment for an individual patient in an individual circumstance.''.

At the end of subtitle G of title I, add the following:

SEC. 15___. IDENTIFICATION OF FEDERAL GOVERNMENT HEALTH CARE RATIONING.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct, and submit to Congress a report describing the results of, a study that compares, with regard to the programs described in subsection (b)—

(1) any restrictions or limitations regarding access to health care providers (including the percentage of health care providers willing or permitted to care for patients insured by each program);

(2) any restrictions, denials, or rationing relating to the provision of health care, including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies;

(3) average wait times to see a primary care doctor;

(4) average wait times for medically necessary surgeries and medical procedures; and

(5) the estimated waste, fraud, and abuse (including improper payments) in each program.

(b) PROGRAMS.—The programs referred to in subsection (a) are—

(1) Medicare;

(2) Medicaid;

(3) the Indian Health Service;

(4) the Department of Veterans Affairs; and

(5) the Federal Employee Health Benefits Program.

SA 2965. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After title IX, insert the following:

TITLE X—CERTIFICATION OF FINANCIAL SUSTAINABILITY AND FISCAL SOLVENCY

SEC. 10001. FINANCIAL SUSTAINABILITY AND FISCAL SOLVENCY REQUIREMENT.

Notwithstanding any other provision of law, the provisions of this Act (and the amendments made by this Act), including any health insurance programs created, run, or expanded by the government through this Act (or the amendments made by this Act), shall not take effect unless the actuary of the Department of Health and Human Services and the actuary of the Social Security Administration each independently certify, in testimony before Congress and in an official report to Congress, that, as of January 1, 2009, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) are financially sustainable and fiscally solvent through January 1, 2029.

SA 2966. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 621, strike line 10 and all that follows through page 1134, line 3, and insert the following:

TITLE III—REDUCING WASTE, FRAUD, AND ABUSE IN MEDICARE AND MEDICAID

SEC. 3001. PREVENTION AND DETECTION OF WASTE, FRAUD, AND ABUSE WITHIN THE MEDICARE AND MEDICAID PROGRAMS.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall develop and implement innovative technologies, systems, and procedures (as described under subsection (b)) to reduce waste, fraud, and abuse under the Medicare and Medicaid programs and ensure that amounts attributed to waste, fraud, and abuse constitute an amount not greater than 5 percent of all funds expended under the Medicare program.

(b) PREVENTION AND DETECTION MEASURES.—For purposes of subsection (a), the technologies, systems, and procedures to be developed and implemented by the Secretary shall include the following:

(1) Improving the Medicare beneficiary identifier (MBI) used to identify beneficiaries under the Medicare program to—

(A) ensure that the social security account numbers assigned to such beneficiaries are not used;

(B) provide such beneficiaries with machine-readable identification cards that employ a unique patient number; and

(C) establish a process for changing the MBI for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(2) Comprehensive real-time data matching across Federal agencies (similar to measures employed by the credit card industry) that is able to determine—

(A) whether a beneficiary under the Medicare or Medicaid programs is dead, imprisoned, or otherwise not eligible for benefits under such programs; and

(B) whether a provider of services or a supplier under the Medicare or Medicaid programs is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such programs.

(3) Imposition of direct financial penalties to facilities receiving funds under the Medicare or Medicaid programs that employ any physician, executive, or administrator that has been convicted of an offense involving fraud relating to the Medicare or Medicaid programs or reached a settlement relating to such an offense with the Federal Government or any State government.

(4) Use of procedures and technology (including front-end, pre-payment technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under the Medicare program to identify and investigate unusual billing or order practices that could indicate fraud or abuse.

(c) INVESTIGATION.—The Secretary shall, in the case where a provider of services or a supplier under the Medicare or Medicaid programs submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information obtained pursuant to subsection (b), is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, refer the matter to the Inspector General of the Department of Health and Human Services for investigation not later than 14 days after the Secretary has made such a determination.

(d) DEFINITIONS.—In this title:

(1) MEDICAID.—The term ''Medicaid'' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) MEDICARE.—The term ''Medicare'' means the program for medical assistance established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 3002. REINVESTMENT OF SAVINGS INTO MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary under section 3001 shall be reinvested into the Federal Hospital Insurance Trust Fund, as established under section 1817 of the Social Security Act (42 U.S.C. 1395i), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395t).

SEC. 3003. USING HEALTH CARE PROFESSIONALS TO REDUCE FRAUD.

(a) IN GENERAL.—The Secretary shall establish a demonstration project that uses practicing health care professionals to conduct undercover investigations of other health care professionals.

(b) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary, in coordination with the Office of the Inspector General of the Department of Health and Human Services (referred to in this section as the ''Inspector General''), shall establish a demonstration project in which the Secretary enters into contracts with practicing health care professionals to conduct investigations of health care providers that receive reimbursements through any Federal public health care program.

(2) SCOPE.—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud; or

(B) any level of Medicaid fraud.

(c) ELIGIBILITY.—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) ACTIVITIES.—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) FOLLOW-UP BY THE INSPECTOR GENERAL.—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) LIMITATION.—The Secretary shall not contract with a health care professional if, due to physical proximity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) FUNDING.—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, $500,000 for each of fiscal years 2010 through 2014.

SA 2967. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 124, line 1 insert ''OTHER'' before ''FEDERAL''.

On page 124, line 4, insert ''other'' before ''Federal''.

On page 124, between lines 22 and 23, insert the following:

SEC. 1304. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

(a) NONDISCRIMINATION.—A Federal agency or program, and any State or local government, or institutional health care entity that receives Federal financial assistance under this Act (or an amendment made by this Act), shall not—

(1) subject any individual or institutional health care entity to discrimination; or

(2) require any health care entity that is established or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination;

on the basis that such health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsor, a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or plan.

(c) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

SA 2968. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike subtitle D of title IV and insert the following:

Subtitle D—Prohibition on Comparative Effectiveness Research for the Purpose of Determining Cost and Coverage Decisions

SEC. 4301. PROHIBITION ON COMPARATIVE EFFECTIVENESS RESEARCH FOR THE PURPOSE OF DETERMINING COST AND COVERAGE DECISIONS.

Reports and recommendations from the Patient-Centered Outcomes Research Institute, established under section 1181 of the Social Security Act (as added by section 6301), are prohibited from being used by any government entity for payment, coverage, or treatment decisions based on cost. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of such Institute when making decisions about the best treatment for an individual patient in an individual circumstance.

SA 2969. Mr. COBURN (for himself, Mr. GRASSLEY, Mr. BURR, Mr. VITTER, Mrs. MCCASKILL, and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr.

BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 156, line 4, strike all through page 157, line 7, and insert the following:

(D) REQUIREMENT OF MEMBERS OF CONGRESS AND OTHERS TO ENROLL IN THE PUBLIC OPTION.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, all Federal officers shall be enrolled in the community health insurance option when established by the Secretary.

(ii) INELIGIBLE FOR FEHBP.—Effective on the date on which the community health insurance option is established by the Secretary, no Federal officer shall be eligible to participate in a health benefits plan under chapter 89 of title 5, United States Code.

(iii) EMPLOYER CONTRIBUTION.—

(I) IN GENERAL.—The appropriate disbursing officer for each Federal officer shall pay the amount determined under subclause (II) to—

(aa) the appropriate community health insurance option; or

(bb) in the case of a Federal officer who resides in a State which opts out of providing a community health insurance option and is enrolled in a plan offered through an Exchange, the appropriate Exchange.

(II) AMOUNT OF EMPLOYER CONTRIBUTION.—The Director of the Office of Personnel Management shall determine the amount of the employer contribution for each Federal officer. The amount shall be equal to the employer contribution for the health benefits plan under chapter 89 of title 5, United States Code, with the greatest number of enrollees, except that the contribution shall be actuarially adjusted for age.

(iv) DEFINITIONS.—In this subparagraph:

(I) COMMUNITY HEALTH INSURANCE OPTION.—The term ''community health insurance option'' means the health insurance established by the Secretary under section 1323.

(II) CONGRESSIONAL EMPLOYEE.—The term ''congressional employee'' means an employee of—

(aa) a committee of the Senate or House of Representatives;

(bb) the office of a Member of Congress;

(cc) the Majority Leader of the Senate;

(dd) the Minority Leader of the Senate;

(ee) the Speaker of the House of Representatives; or

(ff) the Minority Leader of the House of Representatives;

(III) FEDERAL OFFICER.—The term ''Federal officer'' means—

(aa) a Member of Congress;

(bb) the President;

(cc) the Vice President;

(dd) a political appointee; and

(ee) a congressional employee.

(IV) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

(V) POLITICAL APPOINTEE.—The term ''political appointee'' means any individual who—

(aa) is employed in a position described under sections 5312 through 5316 of title 5, United States Code, (relating to the Executive Schedule);

(bb) is a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of section 3132(a) of title 5, United States Code; or

(cc) is employed in a position in the executive branch of the Government of a confidential or policy-determining character under schedule C of subpart C of part 213 of title 5 of the Code of Federal Regulations.

SA 2970. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___PULMONARY HYPERTENSION RESEARCH AND EDUCATION

SEC. _01. SHORT TITLE.

This title may be cited as the ''Tom Lantos Pulmonary Hypertension Research and Education Act of 2009''.

Subtitle A—Research on Pulmonary Hypertension

SEC. _11. EXPANSION AND INTENSIFICATION OF ACTIVITIES.

(a) SENSE OF CONGRESS.—It is the sense of the Congress that—

(1) the Secretary of Health and Human Services (in this Act referred to as the ''Secretary''), acting through the Director of the National Institutes of Health and the Director of the National Heart, Lung, and Blood Institute (in this title referred to as the ''Institute''), should continue aggressive work on pulmonary hypertension;

(2) as part of such work, the Director of the Institute should continue research to expand the understanding of the causes of, and to find a cure for, pulmonary hypertension; and

(3) activities under paragraph (1) may include conducting and supporting—

(A) basic research concerning the etiology and causes of pulmonary hypertension;

(B) basic research on the relationship between scleroderma, sickle cell anemia (and other conditions identified by the Director of the Institute that can lead to a secondary diagnosis of pulmonary hypertension), and pulmonary hypertension;

(C) clinical research for the development and evaluation of new treatments for pulmonary hypertension, including the establishment of a ''Pulmonary Hypertension Clinical Research Network'';

(D) support for the training of new clinicians and investigators with expertise in the pulmonary hypertension; and

(E) information and education programs for the general public.

(b) BIENNIAL REPORTS.—As part of the biennial report made under section 403 of the Public Health Service Act (42 U.S.C. 283), the Secretary shall include information on the status of pulmonary hypertension research at the National Institutes of Health.

Subtitle B—Increasing Awareness of Pulmonary Hypertension

SEC. _21. PROMOTING PUBLIC AWARENESS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out an educational campaign to increase public awareness of pulmonary hypertension. Print, video, and Web-based materials distributed under this program may include—

(1) basic information on pulmonary hypertension and its symptoms; and

(2) information on—

(A) the incidence and prevalence of pulmonary hypertension;

(B) diseases and conditions that can lead to pulmonary hypertension as a secondary diagnosis;

(C) the importance of early diagnosis; and

(D) the availability, as medically appropriate, of a range of treatment options and pulmonary hypertension.

(b) DISSEMINATION OF INFORMATION.—The Secretary is encouraged to disseminate information under subsection (a) through a cooperative agreement with a national nonprofit entity with expertise in pulmonary hypertension.

(c) REPORT TO CONGRESS.—Not later than September 30, 2010, the Secretary shall report to the Committee on Energy and Commerce of the House of Representatives, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Appropriations of the House of Representatives and the Senate on the status of activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $2,500,000 for each of fiscal years 2010, 2011, and 2012.

SEC. _22. PROMOTING AWARENESS AMONG HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention, shall carry out an educational campaign to increase awareness of pulmonary hypertension among health care providers. Print, video, and Web-based materials distributed under this program may include information on—

(1) the symptoms of pulmonary hypertension;

(2) the importance of early diagnosis;

(3) current diagnostic criteria; and

(4) Food and Drug Administration-approved therapies for the disease.

(b) TARGETED HEALTH CARE PROVIDERS.—Health care providers targeted through the campaign under subsection (a) shall include, but not be limited to, cardiologists, pulmonologists, rheumatologists, primary care physicians, pediatricians, and nurse practitioners.

(c) DISSEMINATION OF INFORMATION.—The Secretary is encouraged to disseminate information under subsection (a) through a cooperative agreement with a national nonprofit entity with expertise in pulmonary hypertension.

(d) REPORT TO CONGRESS.—Not later than September 30, 2010, the Secretary shall report to the Committee on Energy and Commerce of the House of Representatives, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Appropriations of the House of Representatives and the Senate on the status of activities under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $2,500,000 for each of fiscal years 2010, 2011, and 2012.

SA 2971. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other

purposes; which was ordered to lie on the table; as follows:

On page 731, strike line 9 and all that follows through line 16 and insert the following:

clude a teaching hospital or medical school, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

''(xix) Determining the efficacy of methods to change education models and the practice of community based physicians for higher quality and more cost effective care, to be conducted by a new, freestanding medical school working in a collaborative model with an insurer, community hospitals, private practice physicians, and other health professionals.

SA 2972. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 731, between lines 16 and 17, insert the following:

''(xvii) Funding the use of telehealth systems to facilitate acute stroke therapy services furnished to Medicare beneficiaries in both rural and urban areas that are administered by board eligible or board certified vascular neurologists and coordinated by a certified stroke center.''.

SA 2973. Mrs. MURRAY (for herself and Ms. STABENOW) submitted an amendment intended to be proposed by her to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

''Subpart XI—Community-Based Collaborative Care Network Program

''SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

''(a) IN GENERAL.—The Secretary may award grants to eligible entities for the purpose of establishing model projects to accomplish the following goals:

''(1) To reduce unnecessary use of items and services furnished in emergency departments of hospitals (especially to ensure that individuals without health insurance coverage or with inadequate health insurance coverage do not use the services of such department instead of the services of a primary care provider) through methods such as—

''(A) screening individuals who seek emergency department services for possible eligibility under relevant governmental health programs or for subsidies under such programs; and

''(B) providing such individuals referrals for followup care and chronic condition care.

''(2) To manage chronic conditions to reduce their severity, negative health outcomes, and expense.

''(3) To encourage health care providers to coordinate their efforts so that the most vulnerable patient populations seek and obtain primary care.

''(4) To provide more comprehensive and coordinated care to vulnerable low-income individuals and individuals without health insurance coverage or with inadequate coverage.

''(5) To provide mechanisms for improving both quality and efficiency of care for low-income individuals and families, with an emphasis on those most likely to remain uninsured despite the existence of government programs to make health insurance more affordable.

''(6) To increase preventive services, including screening and counseling, to those who would otherwise not receive such screening, in order to improve health status and reduce long-term complications and costs.

''(7) To ensure the availability of community-wide safety net services, including emergency and trauma care.

''(b) ELIGIBILITY AND GRANTEE SELECTION.—

''(1) APPLICATION.—A community-based collaborative care network described in subsection (d) shall submit to the Secretary an application in such form and manner and containing such information as specified by the Secretary. Such information shall at least—

''(A) identify the health care providers participating in the community-based collaborative care network proposed by the applicant and, if a provider designated in paragraph (d)(1)(B) is not included, the reason such provider is not so included;

''(B) include a description of how the providers plan to collaborate to provide comprehensive and integrated care for low-income individuals, including uninsured and underinsured individuals;

''(C) include a description of the organizational and joint governance structure of the community-based collaborative care network in a manner so that it is clear how decisions will be made, and how the decision-making process of the network will include appropriate representation of the participating entities;

''(D) define the geographic areas and populations that the network intends to serve;

''(E) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3);

''(F) demonstrate the network's ability to meet the requirements of this section; and

''(G) provide assurances that grant funds received shall be used to support the entire community-based collaborative care network.

''(2) SELECTION OF GRANTEES.—

''(A) IN GENERAL.—The Secretary shall select community-based collaborative care networks to receive grants from applications submitted under paragraph (1) on the basis of quality of the proposal involved, geographic diversity (including different States and regions served and urban and rural diversity), and the number of low-income and uninsured individuals that the proposal intends to serve.

''(B) PRIORITY.—The Secretary shall give priority to proposals from community-based collaborative care networks that—

''(i) include the capability to provide the broadest range of services to low-income individuals; and

''(ii) include providers that currently serve a high volume of low-income individuals.

''(C) RENEWAL.—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

''(3) SUGGESTED CORE SERVICES.—For purposes of paragraph (1)(E), the Secretary shall develop a list of suggested core patient and core network services to be provided by a community-based collaborative care network. The Secretary may select a community-based collaborative care network under paragraph (2), the application of which does not include all such services, if such application provides a reasonable explanation why such services are not proposed to be included, and the Secretary determines that the application is otherwise high quality.

''(4) TERMINATION AUTHORITY.—The Secretary may terminate selection of a community-based collaborative care network under this section for good cause. Such good cause shall include a determination that the network—

''(A) has failed to provide a comprehensive range of coordinated and integrated health care services as required under subsection (d)(2);

''(B) has failed to meet reasonable quality standards;

''(C) has misappropriated funds provided under this section; or

''(D) has failed to make progress toward accomplishing goals set out in subsection (a).

''(c) USE OF FUNDS.—

''(1) USE BY GRANTEES.—Grant funds are provided to community-based collaborative care networks to carry out the following activities:

''(A) Assist low-income individuals without adequate health care coverage to—

''(i) access and appropriately use health services;

''(ii) enroll in applicable public or private health insurance programs;

''(iii) obtain referrals to and see a primary care provider in case such an individual does not have a primary care provider; and

''(iv) obtain appropriate care for chronic conditions.

''(B) Improve health care by providing case management, application assistance, and appropriate referrals such as through methods to—

''(i) create and meaningfully use a health information technology network to track patients across collaborative providers;

''(ii) perform health outreach, such as by using neighborhood health workers who may inform individuals about the availability of safety net and primary care providers available through the community-based collaborative care network;

''(iii) provide for followup outreach to remind patients of appointments or follow-up care instructions;

''(iv) provide transportation to individuals to and from the site of care;

''(v) expand the capacity to provide care at any provider participating in the community-based collaborative care network, including telehealth, hiring new clinical or administrative staff, providing access to services after-hours, on weekends, or otherwise providing an urgent care alternative to an emergency department; and

''(vi) provide a primary care provider or medical home for each network patient.

''(C) Provide direct patient care services as described in their application and approved by the Secretary.

''(2) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant

funding that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration (in this section referred to as 'HRSA') or impose other requirements on HRSA grantees participating in a community-based collaborative care network as may be necessary for consistency with the requirements of such programs.

''(3) RESERVATION OF FUNDS FOR NATIONAL PROGRAM PURPOSES.—The Secretary may use not more than 7 percent of funds appropriated to carry out this section for providing technical assistance to grantees, obtaining assistance of experts and consultants, holding meetings, developing of tools, disseminating of information, and evaluation.

''(d) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

''(1) IN GENERAL.—

''(A) DESCRIPTION.—A community-based collaborative care network described in this subsection is a consortium of health care providers with a joint governance structure that provides a comprehensive range of coordinated and integrated health care services for low-income patient populations or medically underserved communities (whether or not such individuals receive benefits under title XVIII, XIX, or XXI of the Social Security Act, private or other health insurance or are uninsured or underinsured) and that complies with any applicable minimum eligibility requirements that the Secretary may determine appropriate.

''(B) REQUIRED INCLUSION.—Each such network shall include the following providers that serve the community (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation)—

''(i) A safety net hospital that provides services to a high volume of low-income patients, as demonstrated by meeting the criteria in section 1923(b)(1) of the Social Security Act, or other similar criteria determined by the Secretary; and

''(ii) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))) located in the geographic area served by the Coordinated Care Network;

''(C) ADDITIONAL INCLUSIONS.—Funding preferences shall be given to networks that include additional providers such as the following:

''(i) A hospital, including a critical access hospital (as defined in section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2))).

''(ii) A county or municipal department of health.

''(iii) A rural health clinic or a rural health network (as defined in sections 1861(aa) and 1820(d) of the Social Security Act, respectively (42 U.S.C. 1395x(aa), 1395i–4(d))).

''(iv) A community clinic, including a mental health clinic, substance abuse clinic, or a reproductive health clinic.

''(v) A health center controlled network as defined by section 330(e)(1)(C) of the Public Health Service Act.

''(vi) A private practice physician or group practice.

''(vii) A nurse or physician assistant or group practice.

''(viii) An adult day care center.

''(ix) A home health provider.

''(x) Any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

''(D) CONSTRUCTION.—

''(i) Nothing in this section shall prohibit a single entity from qualifying as community-based collaborative care network so long as such single entity meets the criteria of a community-based collaborative care network. If the network does not include the providers referenced in clauses (i) and (ii) of subparagraph (B) of this paragraph, the application must explain the reason pursuant to subsection (b)(1)(A).

''(ii) Participation in a community-based collaborative care network shall not affect Federally qualified health centers' obligation to comply with the governance requirements under section 330 of the Public Health Service Act (42 U.S.C. 254b).

''(iii) Federally qualified health centers participating in a community-based collaborative care network may not be required to provide services beyond their Federal Health Center scope of project approved by HRSA.

''(iv) Nothing in this section shall be construed to expand medical malpractice liability protection under the Federal Tort Claims Act for Section 330-funded Federally qualified health centers.

''(2) COMPREHENSIVE RANGE OF COORDINATED AND INTEGRATED HEALTH CARE SERVICES.—The Secretary shall define criteria for evaluating whether the services offered by a community-based collaborative care network qualify as a comprehensive range of coordinated and integrated health care services. Such criteria may vary based on the needs of the geographic areas and populations to be served by the network and may include the following:

''(A) Requiring community-based collaborative care networks to include at least the suggested core services identified under subsection (b)(3), or whichever subset of the suggested core services is applicable to a particular network.

''(B) Requiring such networks to assign each patient of the network to a primary care provider responsible for managing that patient's care.

''(C) Requiring the services provided by a community-based collaborative care network to include support services appropriate to meet the health needs of low-income populations in the network's community, which may include chronic care management, nutritional counseling, transportation, language services, enrollment counselors, social services and other services as proposed by the network.

''(D) Providing that the services provided by a community-based collaborative care network may also include long-term care services and other services not specified in this subsection.

''(E) Providing for the approval by the Secretary of a scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals available in the community the network serves.

''(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify a health care provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to services otherwise reimbursable under such title. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible to contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

''(e) EVALUATIONS.—

''(1) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each community-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation on the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

''(A) the number of people served;

''(B) the most common health problems treated;

''(C) any reductions in emergency department use;

''(D) any improvements in access to primary care;

''(E) an accounting of how amounts received were used, including identification of amounts used for patient care services as may be required for HRSA grantees; and

''(F) to the extent requested by the Secretary, any quality measures or any other measures specified by the Secretary.

''(2) PROGRAM REPORTS.—The Secretary shall submit to Congress an annual evaluation (beginning not later than 6 months after the first reports under paragraph (1) are submitted) on the extent to which emergency department use was reduced as a result of the activities carried out by the community-based collaborative care network under the program. Each such evaluation shall also include information on—

''(A) the prevalence of certain chronic conditions in various populations, including a comparison of such prevalence in the general population versus in the population of individuals with inadequate health insurance coverage;

''(B) demographic characteristics of the population of uninsured and underinsured individuals served by the community-based collaborative care network involved; and

''(C) the conditions of such individuals for whom services were requested at such emergency departments of participating hospitals.

''(3) AUDIT AUTHORITY.—The Secretary may conduct periodic audits and request periodic spending reports of community-based collaborative care networks under the community-based collaborative care network program.

''(f) CLARIFICATION.—Nothing in this section requires a provider to report individually identifiable information of an individual to government agencies, unless the individual consents, consistent with HIPAA privacy and security law, as defined in section 3009(a)(2).

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SA 2974. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 114, beginning with line 17, strike all through page 116, line 6, and insert the following:

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if the plan provides —

(A) except as provided in subparagraph (B), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until

the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(B) coverage for at least three primary care visits.

(2) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

On page 155, beginning with line 22, strike all through page 156, line 3, and insert the following:

(A) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan.

On page 250, lines 7 through 10, strike '', except that such term shall not include a qualified health plan which is a catastrophic health plan described in section 1302(e) of such Act''.

SA 2975. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 348, strike line 22 and all that follows through line 15 on page 349.

SA 2976. Mr. CARDIN (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. PERMITTING HOME HEALTH AGENCIES TO ASSIGN THE MOST APPROPRIATE SKILLED SERVICE TO MAKE THE INITIAL ASSESSMENT VISIT UNDER A MEDICARE HOME HEALTH PLAN OF CARE FOR REHABILITATION CASES.

(a) IN GENERAL.—Notwithstanding section 484.55(a)(2) of title 42 of the Code of Federal Regulations or any other provision of law, a home health agency may determine the most appropriate skilled therapist to make the initial assessment visit for an individual who is referred (and may be eligible) for home health services under title XVIII of the Social Security Act but who does not require skilled nursing care as long as the skilled service (for which that therapist is qualified to provide the service) is included as part of the plan of care for home health services for such individual.

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed to provide for initial eligibility for coverage of home health services under title XVIII of the Social Security Act on the basis of a need for occupational therapy.

SA 2977. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title IV, insert the following:

SEC. 4208. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

(a) FINDINGS.—Congress finds as follows:

(1) Access to health care in the State of Alaska is challenging due to geographical constraints, health care workforce and treatment facility shortages, and lack of certain medical specialties available in the State.

(2) Delivery of health care to beneficiaries of Federal health care programs is especially challenging in the State of Alaska as a result of capacity constraints at Federal treatment facilities and insufficient civilian provider networks to support Federal systems.

(3) The State of Alaska has the largest, per capita population of veterans, many of whom rely on the health care system of the Department of Veterans Affairs.

(4) The State of Alaska has a large population of active-duty military personnel, military retirees, and dependents of military personnel and retirees who rely on the military health care system. This population will increase as a result of Armed Forces structure initiatives during the next several years.

(5) A significant portion of Alaska's population is comprised of Medicare beneficiaries.

(6) Almost ¼ of Alaska's population is comprised of Medicaid beneficiaries.

(7) Federal agencies have undertaken efforts to improve and increase access to health care in the State of Alaska for Federal health care system beneficiaries, but there are finite medical resources in the State for which such beneficiaries must compete.

(8) To ensure improved and increased access to health care for beneficiaries of Federal health care systems in the State of Alaska, comprehensive policies and interagency collaboration are required.

(b) INTERAGENCY ACCESS TO HEALTH CARE IN ALASKA TASK FORCE.—

(1) ESTABLISHMENT.—There is established a task force to be known as the ''Interagency Access to Health Care in Alaska Task Force'' (referred to in this section as the ''Task Force'').

(2) ACTIVITIES.—The Task Force shall—

(A) assess access to health care for beneficiaries of Federal health care systems in Alaska, which shall include consideration of, with regard to the State of Alaska—

(i) current Federal health care delivery methods at Federal treatment facilities and through civilian provider networks;

(ii) shortfalls in delivering health care to beneficiaries of Federal health care systems at Federal treatment facilities and through civilian provider networks; and

(iii) the impact of reimbursement rates and claims processing on civilian provider participation; and

(B) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska, which shall include—

(i) interagency collaboration opportunities for addressing shortfalls in delivering health care to beneficiaries of Federal health care systems;

(ii) increasing Federal Government primary care and specialty care capability practices in the State of Alaska at Federal treatment facilities and in the civilian provider community.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—

(A) FEDERAL MEMBERS.—The Task Force shall be comprised of Federal members who shall be appointed as follows:

(i) One member shall be a representative of the Department of Health and Human Services and shall be appointed by the Secretary of Health and Human Services.

(ii) One member shall be a representative of the Centers for Medicare and Medicaid Services and shall be appointed by the Secretary of Health and Human Services.

(iii) One member shall be a representative of the Indian Health Service and shall be appointed by the Secretary of Health and Human Services.

(iv) One member shall be a representative of the TRICARE Management Activity and shall be appointed by the Secretary of Defense.

(v) One member shall be a representative of the Army Medical Department and shall be appointed by the Secretary of the Army.

(vi) One member shall be a representative of the Air Force and shall be appointed by the Secretary of the Air Force from among officers at the Air Force performing medical service functions.

(vii) One member shall be a representative of the Department of Veterans Affairs and shall be appointed by the Secretary of Veterans Affairs.

(viii) One member shall be a representative of the Veterans Health Administration and shall be appointed by the Secretary of Veterans Affairs.

(ix) One member shall be a representative of the United States Coast Guard and shall be appointed by the Secretary of Homeland Security.

(B) NON-FEDERAL MEMBERS.—Individuals appointed by the Secretary of Health and Human Services to the Task Force from outside the agencies may include officers or employees of other departments and agencies of the Federal Government and individuals from the private medical community in Alaska and, at the election of the Governor of the State of Alaska, shall include at least one employee representative of the State of Alaska.

(2) TIMEFRAME FOR APPOINTMENT.—All appointments of individuals to the Task Force, as described in paragraph (2), shall be made not later than 45 days after the date of enactment of this Act.

(3) CO-CHAIRPERSONS.—There shall be 2 co-chairpersons of the Task Force, appointed at the time of appointment of members under paragraph (1). One co-chairperson shall be designated by the Secretary of Health and Human Services from among the representatives of the Department of Health and Human Services who are appointed to the Task Force under clauses (i) through (iii) of paragraph (2), and one co-chairperson shall be designated by the Secretary of Health and Human Services from among the members appointed under clauses (iv) through (ix) of such paragraph.

(4) VACANCIES.—A vacancy in the Task Force shall be filled in the manner in which the original appointment was made.

(5) COMPENSATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), members of the Task Force may not receive pay, allowances, or benefits by reason of such member's service on the Task Force.

(B) TRAVEL EXPENSES.—The members of the Task Force shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Task Force.

(d) MEETINGS.—The Task Force shall meet at the call of the chairperson.

(e) REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duties of the Task Force under subsection (b)(2).

(2) CONSIDERATION OF OTHER EFFORTS.—In preparing the report described in paragraph (1), the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

(f) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (e).

SA 2978. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After section 3510, insert the following:

SEC. 3511. ASSISTANCE FOR FRONTIER CLINICS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 4303, is further amended by adding at the end the following:

"PART V—ASSISTANCE FOR FRONTIER CLINICS

"SEC. 399NN. ASSISTANCE FOR FRONTIER CLINICS.

''(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary'), acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible health clinics for the purpose of ensuring access to needed emergency care in frontier areas 24-hours per day, 7 days per week, and to ensure the health and safety of patients at such clinics.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall be—

''(1) located in a community where the closest short-term acute care hospital or critical access hospital is—

''(A) at least 60 miles or one hour usual travel time from such community; or

''(B) inaccessible by public road; and

''(2) designed to address the needs of—

''(A) seriously or critically ill or injured patients for stabilization prior to transport to definitive care; or

''(B) patients who need monitoring and observation for a limited period of time.

''(c) PRIORITY.—In awarding grants under this section, the Secretary shall ensure that not less than 25 percent of the entities receiving such a grant are located in communities from which the nearest short-term acute care hospital or critical access hospital is at least 75 miles or is inaccessible by public road.

''(d) USE OF FUNDS.—Entities receiving a grant under this section shall use such grant funds to meet quality standards established for the staffing, equipment, or health care facility of such entity.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2011 through 2015.''.

SA 2979. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

After title IX, insert the following:

TITLE X—INCREASING ACCESS TO PRIMARY CARE SERVICES

SEC. 10001. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.

(a) IN GENERAL.—A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

(b) SOURCE OF FUNDS.—A grant program established by a State under subsection (a) may not be established within a department, agency, or other entity of such State that administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10, United States Code, may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a).

SEC. 10002. INCENTIVE PAYMENTS FOR PRIMARY CARE PHYSICIANS WHO TREAT A CERTAIN PERCENTAGE OF NEW MEDICARE PATIENTS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 5501, is further amended by adding at the end the following new subsection:

''(z) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES PROVIDED TO NEW MEDICARE PATIENTS.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by an eligible primary care practitioner in a calendar year, in addition to the amount of payment that would otherwise be made for such services under this part, including any payment available under subsection (x), there also shall be paid (on a monthly or quarterly basis) an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection—

''(A) the term 'eligible primary care provider' means a primary care practitioner for whom, of all patients for whom such practitioner provides primary care services in a calendar year and for whom such practitioner did not provide such services in the previous calendar year, 10 percent of such patients are enrollees under this part;

''(B) the terms 'primary care practitioner' and 'primary care services' have the meanings given such terms in subsection (x)(2).

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsections (m) and (x) shall be determined without regard to any additional payment for the service under subsection (m), subsection (x), and this subsection, respectively.

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by section 5501(b)(2), is further amended by striking ''(x) and (y)'' in the last sentence and inserting ''(x), (y), and (z)''.

(2) Section 1834(x)(3) of such Act, as added by section 5501, is amended—

(A) by striking ''subsection (m)'' the first place it appears and inserting ''subsections (m) and (z)''; and

(B) by striking ''subsection (m) and'' and inserting ''subsection (m), subsection (z), and''.

SEC. 10003. FACULTY LOAN REPAYMENT FOR PHYSICIAN ASSISTANTS.

Section 738(a)(3) of the Public Health Service Act (42 U.S.C.293b(a)(3)) is amended by inserting ''schools offering physician assistant education programs,'' after ''public health,''.

SEC. 10004. ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAM.

Section 1899(b)(2)(D) of the Social Security Act, as added by section 3022, is amended by adding at the end: ''Notwithstanding the preceding sentence, the Secretary may approve for participation in the program any ACO, with any number of Medicare fee-for-service beneficiaries assigned to such ACO, that proposes a plan that would improve efficiencies and provide cost savings.''

SEC. 10005. AMERICAN PRIMARY CARE CORPS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish an American Primary Care Corps (referred to in this section as the ''program'') for the purpose of encouraging health care practitioners who are recent graduates of a health care program to enter into primary care practice, by providing incentive payments to eligible primary care practitioners.

(b) DEFINITIONS.—In this section:

(1) PRIMARY CARE PRACTITIONER.—The term ''primary care practitioner'' means a health care provider, including a physician, dentist, nurse practitioner, and physician assistant, who primarily provides primary health services.

(2) PRIMARY CARE SERVICES.—The term ''primary health services'' has the meaning given such term in section 331(a)(3)(D) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(D)).

(c) PROGRAM.—

(1) IN GENERAL.—The Secretary shall select recipients of the incentive payment awards under this section from among eligible primary care practitioners. Each recipient of such an award shall receive incentive payments, as described in paragraph (2), for a period of 3 years, provided such recipient continues to maintain active employment as a primary care practitioner.

(2) INCENTIVE PAYMENTS.—The Secretary shall award incentive payments, on a competitive basis, to eligible primary care practitioners as follows:

(A) In the first year that a practitioner receives an award under the program, such practitioner shall receive an incentive payment in an amount that is equal to 75 percent of the salary for such year received by such practitioner for employment as a primary care practitioner.

(B) In the second year that a practitioner receives an award under the program, such practitioner shall receive an incentive payment in an amount that is equal to 50 percent of the salary for such year received by such practitioner for employment as a primary care practitioner.

(C) In the third year that a practitioner receives an award under the program, such

practitioner shall receive an incentive payment in an amount that is equal to 25 percent of the salary for such year received by such practitioner for employment as a primary care practitioner.

(d) ELIGIBLE PRIMARY CARE PRACTITIONERS.—To be eligible to receive an incentive payment under this section, an individual shall—

(1) be actively employed as a primary care practitioner, or have arrangements to commence active employment as a primary care practitioner;

(2) have graduated, not more than 2 years after the date on which such individual would begin receiving incentive payments under this program, from an accredited program that qualifies such individual to maintain employment as a primary care practitioner; and

(3) submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(e) DURATION OF PROGRAM.—The Secretary shall make awards under this section for each of fiscal years 2011 through 2015. Each such recipient shall remain in the program for a 3-year period, as described in subsection (c), provided such recipient continues to maintain active employment as a primary care practitioner.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015, and such sums as may be necessary for fiscal years 2016 and 2017.

SA 2980. Ms. MIKULSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 84, line 10, insert ''sterilization'' after ''including''.

On page 95, between lines 7 and 8, insert the following:

''SEC. 2705A. PROHIBITING CONSIDERATION OF PRIOR HISTORY OF STERILIZATION, DOMESTIC VIOLENCE, OR MEDICALLY NECESSARY CESAREAN SECTION AS A CONDITION FOR ISSUING HEALTH INSURANCE COVERAGE.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not, with respect to an individual desiring to enroll in coverage, take any of the following actions based on evidence of sterilization, domestic violence, or medically necessary cesarean section with respect to such individual:

''(1) Decline to offer coverage to such individual.

''(2) Deny enrollment of such individual in the lan or coverage.

''(3) Establish rules of eligibility (including continued eligibility) for such individual under the plan or coverage.

''(4) Require such individual to pay an additional premium or contribution amount based solely on evidence of sterilization.

''(5) Require sterilization as a condition to offer coverage.''.

On page 99, line 23, insert before the period the following: '', except that the provisions of section 2705A of the Public Health Service Act (as added by such amendments) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act''.

SA 2981. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 19, line 19, insert before the period the following: ''and for form and rate filings with respect to issuers''.

On page 24, line 14, insert ''(including standards relating to form and rate fillings)'' after ''section''.

SA 2982. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 621, between lines 9 and 10, insert the following:

SEC. 2956. INFANT EYE AND VISION ASSESSMENT.

(a) INCLUSION IN MATERNAL AND CHILD HEALTH SERVICES PROGRAM.—Subsection (a)(2) of section 501 of the Social Security Act (42 U.S.C. 701) is amended—

(1) by striking ''and'' after ''without regard to age,''; and

(2) by inserting after ''follow-up services'' the following: '', and for infant eye and vision assessment promotion''.

(b) DEFINITION.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

''(5) The term 'infant eye and vision assessment promotion' means a nationally established program for the promotion of—

''(A) comprehensive eye and vision assessments provided to infants who have attained 6 months, but not 12 months, in age without charge;

''(B) the development and dissemination of parental information and education materials on infant eye and vision health;

''(C) increased participation by optometrists to perform infant eye and vision assessments; and

''(D) public and private partnerships at the State and local levels for the provision of such eye and vision assessments.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2010.

SA 2983. Mr. REID (for Mr. BYRD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1265, between lines 8 and 9, insert the following:

SEC. 4307. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

''SEC. 544. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

''(a) PROGRAM.—The Secretary, acting through the Administrator, shall establish a program (consisting of awarding grants, contracts, and cooperative agreements under subsection (b)) on mental health and substance abuse screening, brief intervention, referral, and recovery services for individuals in primary health care settings.

''(b) USE OF FUNDS.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, entities—

''(1) to provide mental health and substance abuse screening, brief interventions, referral, and recovery services;

''(2) to coordinate such services with primary health care services in the same program and setting;

''(3) to develop a network of facilities to which patients may be referred if needed;

''(4) to purchase needed screening and other tools that are—

''(A) necessary for providing such services; and

''(B) supported by evidence-based research; and

''(5) to maintain communication with appropriate State mental health and substance abuse agencies.

''(c) ELIGIBILITY.—To be eligible for a grant, contract, or cooperative agreement under this section, an entity shall be a public or private nonprofit entity that—

''(1) provides primary health services;

''(2) seeks to integrate mental health and substance abuse services into its service system;

''(3) has developed a working relationship with providers of mental health and substance abuse services;

''(4) demonstrates a need for the inclusion of mental health and substance abuse services in its service system; and

''(5) agrees—

''(A) to prepare and submit to the Secretary at the end of the grant, contract, or cooperative agreement period an evaluation of all activities funded through the grant, contract, or cooperative agreement; and

''(B) to use such performance measures as may be stipulated by the Secretary for purposes of such evaluation.

''(d) PREFERENCE.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall give preference to entities that—

''(1) provide services in rural or underserved areas of the United States;

''(2) provide services to entities in States that have high percentages of populations with substance abuse or mental health problems; or

''(3) provide services in school-based health clinics or on university and college campuses.

''(e) DURATION.—The period of a grant, contract, or cooperative agreement under this section may not exceed 5 years.

''(f) REPORT.—Not later than 4 years after the first appropriation of funds to carry out this section, the Secretary shall submit a report to the Congress on the program under this section—

''(1) that includes an evaluation of the benefits of integrating mental health and substance abuse care within primary health care; and

''(2) focusing on the performance measures stipulated by the Secretary under subsection (c)(5).

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated $30,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

''(2) PROGRAM MANAGEMENT.—Of the funds appropriated to carry out this section for a fiscal 5 year, the Secretary may use not more than 5 percent to manage the program under this section.''.

SA 2984. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.

(a) IN GENERAL.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a) is amended to read as follows:

''(b) CLARIFICATION OF USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.—

''(1) IN GENERAL.—Nothing in this title shall prohibit a medicare beneficiary from entering into a private contract with a physician or health care practitioner for the provision of medicare covered professional services (as defined in paragraph (5)(C)) if—

''(A) the services are covered under a private contract that is between the beneficiary and the physician or practitioner and meets the requirements of paragraph (2);

''(B) under the private contract no claim for payment for services covered under the contract is to be submitted (and no payment made) under part A or B, under a contract under section 1876, or under an MA plan (other than an MSA plan); and

''(C)(i) the Secretary has been provided with the minimum information necessary to avoid any payment under part A or B for services covered under the contract, or

''(ii) in the case of an individual enrolled under a contract under section 1876 or an MA plan (other than an MSA plan) under part C, the eligible organization under the contract or the MA organization offering the plan has been provided the minimum information necessary to avoid any payment under such contract or plan for services covered under the contract.

''(2) REQUIREMENTS FOR PRIVATE CONTRACTS.—The requirements in this paragraph for a private contract between a medicare beneficiary and a physician or health care practitioner are as follows:

''(A) GENERAL FORM OF CONTRACT.—The contract is in writing and is signed by the medicare beneficiary.

''(B) NO CLAIMS TO BE SUBMITTED FOR COVERED SERVICES.—The contract provides that no party to the contract (and no entity on behalf of any party to the contract) shall submit any claim for (or request) payment for services covered under the contract under part A or B, under a contract under section 1876, or under an MA plan (other than an MSA plan).

''(C) SCOPE OF SERVICES.—The contract identifies the medicare covered professional services and the period (if any) to be covered under the contract, but does not cover any services furnished—

''(i) before the contract is entered into; or

''(ii) for the treatment of an emergency medical condition (as defined in section 1867(e)(1)(A)), unless the contract was entered into before the onset of the emergency medical condition.

''(D) CLEAR DISCLOSURE OF TERMS.—The contract clearly indicates that by signing the contract the medicare beneficiary—

''(i) agrees not to submit a claim (or to request that anyone submit a claim) under part A or B (or under section 1876 or under an MA plan, other than an MSA plan) for services covered under the contract;

''(ii) agrees to be responsible, whether through insurance or otherwise, for payment for such services and understands that no reimbursement will be provided under such part, contract, or plan for such services;

''(iii) acknowledges that no limits under this title (including limits under paragraphs (1) and (3) of section 1848(g)) will apply to amounts that may be charged for such services;

''(iv) acknowledges that medicare supplemental policies under section 1882 do not, and other supplemental health plans and policies may elect not to, make payments for such services because payment is not made under this title; and

''(v) acknowledges that the beneficiary has the right to have such services provided by (or under the supervision of) other physicians or health care practitioners for whom payment would be made under such part, contract, or plan.

Such contract shall also clearly indicate whether the physician or practitioner involved is excluded from participation under this title.

''(3) MODIFICATIONS.—The parties to a private contract may mutually agree at any time to modify or terminate the contract on a prospective basis, consistent with the provisions of paragraphs (1) and (2).

''(4) NO REQUIREMENTS FOR SERVICES FURNISHED TO MSA PLAN ENROLLEES.—The requirements of paragraphs (1) and (2) do not apply to any contract or arrangement for the provision of services to a medicare beneficiary enrolled in an MSA plan under part C.

''(5) DEFINITIONS.—In this subsection:

''(A) HEALTH CARE PRACTITIONER.—The term 'health care practitioner' means a practitioner described in section 1842(b)(18)(C).

''(B) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is enrolled under part B.

''(C) MEDICARE COVERED PROFESSIONAL SERVICES.—The term 'medicare covered professional services' means—

''(i) physicians' services (as defined in section 1861(q), and including services described in section 1861(s)(2)(A)), and

''(ii) professional services of health care practitioners, including services described in section 1842(b)(18)(D),

for which payment may be made under part A or B, under a contract under section 1876, or under a Medicare Advantage plan but for the provisions of a private contract that meets the requirements of paragraph (2).

''(D) MA PLAN; MSA PLAN.—The terms 'MA plan' and 'MSA plan' have the meanings given such terms in section 1859.

''(E) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r).''.

(b) CONFORMING AMENDMENTS CLARIFYING EXEMPTION FROM LIMITING CHARGE AND FROM REQUIREMENT FOR SUBMISSION OF CLAIMS.—Section 1848(g) of the Social Security Act (42 U.S.C. 1395w–4(g)) is amended—

(1) in paragraph (1)(A), by striking ''In'' and inserting ''Subject to paragraph (8), in'';

(2) in paragraph (3)(A), by striking ''Payment'' and inserting ''Subject to paragraph (8), payment'';

(3) in paragraph (4)(A), by striking ''For'' and inserting ''Subject to paragraph (8), for''; and

(4) by adding at the end the following new paragraph:

''(8) EXEMPTION FROM REQUIREMENTS FOR SERVICES FURNISHED UNDER PRIVATE CONTRACTS.—

''(A) IN GENERAL.—Pursuant to section 1802(b)(1), paragraphs (1), (3), and (4) do not apply with respect to physicians' services (and services described in section 1861(s)(2)(A)) furnished to an individual by (or under the supervision of) a physician if the conditions described in section 1802(b)(1) are met with respect to the services.

''(B) NO RESTRICTIONS FOR ENROLLEES IN MSA PLANS.—Such paragraphs do not apply with respect to services furnished to individuals enrolled with MSA plans under part C, without regard to whether the conditions described in subparagraphs (A) through (C) of section 1802(b)(1) are met.

''(C) APPLICATION TO ENROLLEES IN OTHER PLANS.—Subject to subparagraph (B) and section 1852(k)(2), the provisions of subparagraph (A) shall apply in the case of an individual enrolled under a contract under section 1876 or under an MA plan (other than an MSA plan) under part C, in the same manner as they apply to individuals not enrolled under such a contract or plan.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) is amended by adding at the end the following:

''(E) The provisions of section 1848(g)(8) shall apply with respect to exemption from limitations on charges and from billing requirements for services of health care practitioners described in this paragraph in the same manner as such provisions apply to exemption from the requirements referred to in section 1848(g)(8)(A) for physicians' services.''.

(2) Section 1866(a)(1)(O) of such Act (42 U.S.C. 1395cc(a)(1)(O)) is amended by striking ''enrolled with a Medicare Advantage organization under part C'' and inserting ''enrolled with an MA organization under part C (other than under an MSA plan)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 6 months after the date of the enactment of this Act and apply to contracts entered into on or after that date.

SA 2985. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. CONTINUED ABILITY TO PAY FOR HEALTH CARE.

Nothing in this title (or an amendment made by this title) shall be construed to prohibit an individual from purchasing or otherwise paying for health care items or services on an out-of-pocket basis.

SA 2986. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr.

DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 201, between lines 6 and 7, insert the following:

SEC. 1325. PROVIDER CHOICE.

Notwithstanding any other provision of this title, a Consumer Operated and Oriented Plan under section 1322 and a community health insurance option under section 1323 shall not require the participation of health care providers. The participation of such providers shall be on a voluntary basis.

SA 2987. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. PROTECTING THE TAXPAYERS.

The provisions of this title (and the amendments made by this title) shall not apply with respect to a fiscal year if the Director of the Office of Management and Budget fails to certify to Congress that the application of such provisions (and amendments) in such fiscal year will not increase the Federal budget deficit.

SA 2988. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 320, beginning with line 19, strike all through page 340, line 21.

SA 2989. Mr. MENENDEZ (for himself, Mr. SCHUMER, Mr. DODD, Mrs. GILLIBRAND, Mr. KERRY, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 128, line 6, insert '', and includes, as elected under and subject to section 10001, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands''.

Strike section 2005.

On page 2074, after line 25, add the following:

TITLE X—PROVISIONS RELATING TO THE TERRITORIES

SEC. 10001. SPECIAL RULES FOR APPLICATION OF TITLE I TO TERRITORIES.

(a) ONE-TIME ELECTION FOR TREATMENT AND APPLICATION OF FUNDING.—

(1) IN GENERAL.—A territory may elect, in a form and manner specified by the Secretary of Health and Human Services jointly with the Secretary of the Treasury, and not later than October 1, 2013, either—

(A) to be treated as a State for purposes of applying title I (including establishing an Exchange for such territory); or

(B) not to be so treated but instead, to have the dollar limitation otherwise applicable to the territory under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year increased by a dollar amount equivalent to the cap amount determined under subsection (c)(2) for the territory as applied by the Secretary for the fiscal year involved.

(2) CONDITIONS FOR ACCEPTANCE.—The Secretary of Health and Human Services has the nonreviewable authority to accept or reject an election described in paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in subsection (b) between the Secretary of Health and Human Services and the territory and subsection (c); and

(B) subject to the approval of the Secretary of Health and Human Services and the Secretary of the Treasury and subject to such other terms and conditions as the Secretaries may specify.

(3) DEFAULT RULE.—A territory failing to make such an election (or having an election under paragraph (1)(A) not accepted under paragraph (2)) shall be treated as having made the election described in paragraph (1)(B).

(b) AGREEMENT FOR SUBSTITUTION OF PERCENTAGES FOR REDUCTION IN COST-SHARING.—

(1) NEGOTIATION.—In the case of a territory making an election under subsection (a)(1)(A) (in this section referred to as an ''electing territory''), the Secretaries of Health and Human Services and the Treasury shall enter into negotiations with the government of such territory so that, prior to January 1, 2014, there is an agreement reached between the parties on the percentages that shall be applied under paragraph (2) for that territory. The Secretary of Health and Human Services shall not enter into such an agreement unless—

(A) payments made under title I (and the amendments made by such title) with respect to residents of the territory are consistent with the cap established under subsection (c) for such territory and with subsection (d); and

(B) the requirements of paragraphs (3) and (4) are met.

(2) APPLICATION OF SUBSTITUTE PERCENTAGES AND DOLLAR AMOUNTS.—In the case of an electing territory, there shall be substituted in section 1402(b)(2) and section 36B of the Internal Revenue Code of 1986 for 400 percent, 133 percent, and other percentages and dollar amounts specified in such sections, such respective percentages and dollar amounts as are established under the agreement under paragraph (1) consistent with the following:

(A) NO INCOME GAP BETWEEN MEDICAID AND REDUCTION IN COST-SHARING.—The substituted percentages shall be specified in a manner so as to prevent any gap in coverage for individuals between the income level at which medical assistance is available through Medicaid and the income level at which reduced cost-sharing is available under section 1402.

(B) ADJUSTMENT FOR OUT-OF-POCKET RESPONSIBILITY FOR PREMIUMS AND COST-SHARING IN RELATION TO INCOME.—The substituted percentages of the Federal poverty line for income tiers under such sections shall be specified in a manner so that—

(i) individuals eligible for reduced cost-sharing under section 1402 residing in the territory bear the same out-of-pocket responsibility for premiums and cost-sharing in relation to average income for residents in that territory, as

(ii) the out-of-pocket responsibility for premiums and cost-sharing for individuals eligible for reduced cost-sharing under section 1402 residing in the 50 States or the District of Columbia in relation to average income for such residents.

In the case of a territory with a mirror code tax system, the Internal Revenue Code of 1986 shall be applied as if the substitutions permitted under this paragraph were included in such Code.

(3) SPECIAL RULES WITH RESPECT TO APPLICATION OF TAX AND PENALTY PROVISIONS.—The electing territory shall enact one or more laws under which provisions similar to the following provisions apply with respect to such territory:

(A) Section 5000A of the Internal Revenue Code of 1986, except that any resident of the territory who is not eligible for reduced cost-sharing under section 1402 but who would be so eligible if such resident were a resident of one of the 50 States (and any qualifying child residing with such individual) may be treated as covered by minimum essential coverage.

(B) Section 502(c)(11) of the Employee Retirement Income Security Act of 1974.

(C) Section 3121(c) of the Internal Revenue Code of 1986.

(4) IMPLEMENTATION OF INSURANCE REFORM AND CONSUMER PROTECTION REQUIREMENTS.—The electing territory shall enact and implement such laws and regulations as may be required to apply the requirements of subtitles A and C of title I (and the amendments made by such subtitles) with respect to health insurance coverage offered in the territory.

(c) CAP ON ADDITIONAL EXPENDITURES.—

(1) IN GENERAL.—In entering into an agreement with an electing territory under subsection (b), the Commissioner shall ensure that the aggregate expenditures under this section with respect to residents of such territory during the period beginning on January 1, 2014 and ending with 2019 will not exceed the cap amount specified in paragraph (2) for such territory. The Commissioner shall adjust from time to time the percentages applicable under such agreement as needed in order to carry out the previous sentence.

(2) CAP AMOUNT.—

(A) IN GENERAL.—The cap amount specified in this paragraph—

(i) for Puerto Rico is $3,700,000,000 increased by the amount (if any) elected under subparagraph (C); or

(ii) for another territory is the portion of $300,000,000 negotiated for such territory under subparagraph (B).

(B) NEGOTIATION FOR CERTAIN TERRITORIES.—The Secretary of Health and Human Services shall negotiate with the governments of the territories (other than Puerto Rico) to allocate the amount specified in subparagraph (A)(ii) among such territories.

(C) OPTIONAL SUPPLEMENTATION FOR PUERTO RICO.—

(i) IN GENERAL.—Puerto Rico may elect, in a form and manner specified by the Secretary of Health and Human Services to increase the dollar amount specified in subparagraph (A)(i) by up to $1,000,000,000.

(ii) OFFSET IN MEDICAID CAP.—If Puerto Rico makes the election described in clause (i), the Secretary shall decrease the dollar

limitation otherwise applicable to Puerto Rico under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year by the additional aggregate payments the Secretary estimates will be payable under this section for the fiscal year because of such election.

(d) LIMITATION ON FUNDING.—In no case shall this section (including the agreement under subsection (b)) permit—

(1) the obligation of funds for expenditures under this section for periods beginning on or after January 1, 2020; or

(2) any increase in the dollar limitation described in subsection (a)(1)(B) for any portion of any fiscal year occurring on or after such date.

SEC. 10002. MEDICAID PAYMENTS TO TERRITORIES.

(a) INCREASE IN CAP.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(2) in subsection (g)(1), by striking ''With respect to'' and inserting ''Subject to subsection (h), with respect to''; and

(3) by adding at the end the following new subsection:

''(h) ADDITIONAL INCREASE FOR FISCAL YEARS 2011 THROUGH 2019.—Subject to section 10002(b)(1) of the Patient Protection and Affordable Care Act, with respect to fiscal years 2011 through 2019, the amounts otherwise determined under subsections (f) and (g) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa shall be increased by the following amounts:

''(1) For Puerto Rico, for fiscal year 2011, $727,600,000; for fiscal year 2012, $775,000,000; for fiscal year 2013, $850,000,000; for fiscal year 2014, $925,000,000; for fiscal year 2015, $1,000,000,000; for fiscal year 2016, $1,075,000,000; for fiscal year 2017, $1,150,000,000; for fiscal year 2018, $1,225,000,000; and for fiscal year 2019, $1,396,400,000.

''(2) For the Virgin Islands, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(3) For Guam, for fiscal year 2011, $34,000,000; for fiscal year 2012, $37,000,000; for fiscal year 2013, $40,000,000; for fiscal year 2014, $43,000,000; for fiscal year 2015, $46,000,000; for fiscal year 2016, $49,000,000; for fiscal year 2017, $52,000,000; for fiscal year 2018, $55,000,000; and for fiscal year 2019, $58,000,000.

''(4) For the Northern Mariana Islands, for fiscal year 2011, $13,500,000; fiscal year 2012, $14,500,000; for fiscal year 2013, $15,500,000; for fiscal year 2014, $16,500,000; for fiscal year 2015, $17,500,000; for fiscal year 2016, $18,500,000; for fiscal year 2017, $19,500,000; for fiscal year 2018, $21,000,000; and for fiscal year 2019, $22,000,000.

''(5) For American Samoa, fiscal year 2011, $22,000,000; fiscal year 2012, $23,687,500; for fiscal year 2013, $24,687,500; for fiscal year 2014, $25,687,500; for fiscal year 2015, $26,687,500; for fiscal year 2016, $27,687,500; for fiscal year 2017, $28,687,500; for fiscal year 2018, $29,687,500; and for fiscal year 2019, $30,687,500.''.

(b) REPORT ON ACHIEVING MEDICAID PARITY PAYMENTS BEGINNING WITH FISCAL YEAR 2020.—

(1) IN GENERAL.—Not later than October 1, 2013, the Secretary of Health and Human Services shall submit to Congress a report that details a plan for the transition of each territory to full parity in Medicaid with the 50 States and the District of Columbia in fiscal year 2020 by modifying their existing Medicaid programs and outlining actions the Secretary and the governments of each territory must take by fiscal year 2020 to ensure parity in financing. Such report shall include what the Federal medical assistance percentages would be for each territory if the formula applicable to the 50 States were applied. Such report shall also include any recommendations that the Secretary may have as to whether the mandatory ceiling amounts for each territory provided for in section 1108 of the Social Security Act (42 U.S.C. 1308) should be increased any time before fiscal year 2020 due to any factors that the Secretary deems relevant.

(2) PER CAPITA DATA.—As part of such report the Secretary shall include information about per capita income data that could be used to calculate Federal medical assistance percentages under section 1905(b) of the Social Security Act, under section 1108(a)(8)(B) of such Act, for each territory on how such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States. The report under this subsection shall include recommendations on how the Federal medical assistance percentages can be calculated for the territories beginning in fiscal year 2020 to ensure parity with the 50 States.

(3) SUBSEQUENT REPORTS.—The Secretary shall submit subsequent reports to Congress in 2015, 2017, and 2019 detailing the progress that the Secretary and the governments of each territory have made in fulfilling the actions outlined in the plan submitted under paragraph (1).

(c) APPLICATION OF FMAP FOR ADDITIONAL FUNDS.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following sentence: ''Notwithstanding the first sentence of this subsection and any other provision of law, for fiscal years 2011 through 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the highest Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of section 5001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to such States and the District for calendar quarters during such fiscal years for which such subsections apply.''.

(d) WAIVERS.—

(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(A) by striking ''American Samoa and the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa''; and

(B) by striking ''American Samoa or the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply beginning with fiscal year 2011.

(e) TECHNICAL ASSISTANCE.—The Secretary shall provide nonmonetary technical assistance to the governments of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in upgrading their existing computer systems in order to anticipate meeting reporting requirements necessary to implement the plan contained in the report under subsection (b)(1).

SEC. 10003. MEDICARE PROVISIONS RELATING TO PUERTO RICO.

(a) MODIFICATION OF MEDICARE INPATIENT HOSPITAL PAYMENT RATE FOR PUERTO RICO HOSPITALS.—Section 1886(d)(9)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(E)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv), by inserting ''and before April 1, 2010,'' after ''2004,'' and by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) on or after April 1, 2010, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent.''.

(b) APPLICATION OF DEEMED PART B MEDICARE ENROLLMENT RULES TO RESIDENTS OF PUERTO RICO.—

(1) IN GENERAL.—Section 1837(f)(3) of the Social Security Act (42 U.S.C. 1395p(f)(3)) is amended by striking '', exclusive of Puerto Rico''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to individuals whose initial enrollment period under section 1837(d) of the Social Security Act (42 U.S.C. 1395p(d)) begins on or after the first day of the first month that begins more than 60 days after the date of the enactment of this Act.

SA 2990. Mr. MENENDEZ submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(s) of the Social Security Act (42 U.S.C. 1395w(s)) is amended to read as follows:

''(10) federally approved and recommended vaccines (as defined in subsection (hhh)) and their respective administration;''.

(b) FEDERALLY APPROVED AND RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is amended by adding at the end the following new subsection:

''Federally Approved and Recommended Vaccines

''(hhh) The term 'federally approved and recommended vaccine' means a vaccine that—

''(1) is licensed under section 351 of the Public Health Service Act, approved under the Federal Food, Drug, and Cosmetic Act, or authorized for emergency use under section 564 of the Federal, Food, Drug, and Cosmetic Act; and

''(2) is recommended by the Director of the Centers for Disease Control and Prevention.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395l) is amended, in each of subsections (a)(1)(B), (a)(2)(G), and (a)(3)(A), by striking ''1861(s)(10)(A)'' and inserting ''1861(s)(10)'' each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395u(o)(1)(A)(iv)) is amended—

(A) by striking ''subparagraph (A) or (B) of''; and

(B) by inserting before the period the following: ''and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011''.

(3) Section 1847A(c)(6) of such Act (42 U.S.C. 1395w–3a(c)(6)) is amended—

(A) in subparagraph (D)(i), by inserting '', including a vaccine furnished on or after January 1, 2010''; and

(B) by the following new paragraph:

''(H) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to manufacturer provision of information pursuant to section 1927(b)(3)(A)(iii) or subsection (f)(2) for purposes of implementation of this section.''.

(4) Section 1860D–2(e)(1) of such Act (42 U.S.C. 1395w–102(e)(1)) is amended by striking ''such term includes a vaccine'' and all that follows through ''its administration) and''.

(5) Section 1861(ww)(2)(A) of such Act (42 U.S.C. 1395x(ww)(2)(A))) is amended by striking ''Pneumococcal, influenza, and hepatitis B vaccine and administration'' and inserting ''federally approved or authorized vaccines (as defined in subsection (hhh)) and their respective administration''.

(6) Section 1927(b)(3)(A)(iii) of such Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended, in the matter following subclause (III), by inserting ''(A)(iv) (including influenza vaccines furnished on or after January 1, 2011),'' after ''described in subparagraph''.

(7) Section 1847A(f) of such Act (42 U.S.C. 1395w–3a(f)) is amended—

(A) by striking ''For'' and inserting ''(1) IN GENERAL.—For'';

(B) by indenting paragraph (1), as redesignated in subparagraph (A), 2 ems to the left; and—

(C) by adding at the end the following new paragraph:

''(2) TREATMENT OF CERTAIN MANUFACTURERS.—In the case of a manufacturer of a drug or biological described in subparagraphs (A)(iv), (C), (D), (E), or (G) of section 1842(o)(1) that does not have a rebate agreement under section 1927(a), no payment may be made under this part for such drug or biological if such manufacturer does not submit the information described in section 1927(b)(3)(A)(iii) in the same manner as if the manufacturer had such a rebate agreement in effect. Subparagraphs (C) and (D) of section 1927(b)(3) shall apply to information reported pursuant to the previous sentence in the same manner as such subparagraphs apply with respect to information reported pursuant to such section.''.''.

(d) EFFECTIVE DATES.—The amendments made—

(1) by this section (other than by subsection (c)(6)) shall apply to vaccines administered on or after January 1, 2011; and

(2) by subsection (c)(6) shall apply to calendar quarters beginning on or after January 1, 2010.

SA 2991. Mr. MENENDEZ (for himself, Mr. ROCKEFELLER, Mr. BINGAMAN, and Mr. DURBIN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. PERMITTING STATES TO ENSURE COVERAGE WITHOUT A 5-YEAR DELAY OF LAWFULLY RESIDING NONCITIZEN NONPREGNANT ADULTS UNDER MEDICAID.

(a) STATE OPTION.—

(1) IN GENERAL.—Section 1903(v)(4)(A) of the Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is amended—

(A) in the matter preceding clause (i)—

(i) by striking ''children and pregnant women'' and inserting ''individuals''; and

(ii) by striking ''either or both'' and inserting ''any or all''; and

(B) by adding at the end the following:

''(iii) OTHER LAWFULLY RESIDING INDIVIDUALS.—Individuals who are not described in clause (i) or (ii).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on January 1, 2014.

(b) CONFORMING AMENDMENT.—Effective as if enacted on October 1, 2009, subparagraph (H) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by striking ''Paragraph (4) of section 1903(v)'' and inserting ''Clauses (i) and (ii) of section 1903(v)(4)''.

SA 2992. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 867, strike line 15 and all that follows through page 869, line 14, and insert the following:

SEC. 3142. TREATMENT OF URBAN MEDICARE-DEPENDENT HOSPITALS.

Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended by adding at the end the following new subparagraph:

''(M) AUTHORIZATION OF ADJUSTMENT IN AMOUNT OF PAYMENT FOR URBAN MEDICARE-DEPENDENT HOSPITALS.—

''(i) STUDY.—The Secretary shall conduct a study on the need for a payment adjustment under the prospective payment system under this section for urban Medicare-dependent hospitals similar to the adjustment available (as of the date of enactment of this subparagraph) to medicare-dependent, small rural hospitals under subparagraph (G). Such study shall compare the Medicare inpatient operating margins of urban Medicare-dependent hospitals to the Medicare inpatient operating margins of subsection (d) hospitals that receive one or more additional payments or adjustments (as defined in clause (iv)). The Secretary shall finish conducting such study by not later than June 1, 2010.

''(ii) AUTHORIZATION OF ADJUSTMENT.—If the Secretary determines under clause (i) that the average Medicare inpatient operating margin of urban Medicare-dependent hospitals is materially lower than the average Medicare inpatient operating margin of subsection (d) hospitals that receive one or more additional payments or adjustments (as so defined), the Secretary shall provide for an adjustment to the payment amounts to urban Medicare-dependent hospitals under this section similar to the adjustment available to medicare-dependent, small rural hospitals under subparagraph (G). Any such adjustment shall be effective for discharges occurring on or after October 1, 2010.

''(iii) DEFINITION OR URBAN MEDICARE-DEPENDENT HOSPITAL.—In this subparagraph, the term 'urban Medicare-dependent hospital' means a subsection (d) hospital—

''(I) located in an urban area;

''(II) that does not receive any additional payments or adjustments (as so defined);

''(III) that is not a physician-owned hospital, as defined in section 489.3 of title 42, Code of Federal Regulations (as in effect as of the date of the enactment of this subparagraph); and

''(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 2006, or 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

''(iv) ADDITIONAL PAYMENTS OR ADJUSTMENTS DEFINED.—The term 'additional payments or adjustments' means payments or adjustments—

''(I) under subparagraph (C) as a rural referral center;

''(II) under subparagraph (D) as a sole community hospital;

''(III) under subparagraph (B) for indirect medical education costs;

''(IV) under subsection (h) for direct graduate medical education costs;

''(V) under subparagraph (F) for disproportionate share hospital payments; or

''(VI) under subparagraph (G) as a medicare-dependent, small rural hospital.''.

SA 2993. Mr. SCHUMER (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, strike lines 9 through 17 and insert the following:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

''(2) ADJUSTMENT FOR INFLATION.—In the case of a taxable year beginning in any calendar year after 2011, the dollar amount in paragraph (1) shall be increased to the amount equal to such amount as in effect for taxable years beginning in the calendar year preceding such calendar year, increased by an amount equal to the product of—

''(A) such amount as so in effect, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting the calendar year that is 2 years before such calendar year for 'calendar year 1992' in subparagraph (B) thereof, increased by 1 percentage point.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

SA 2994. Mr. SCHUMER (for himself, Mr. AKAKA, Mr. BROWN, Mr. LAUTENBERG, Mr. MERKLEY, Ms. CANTWELL, Mr. KERRY, Mr. LEAHY, Mr. MENENDEZ, and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr.

REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

Subtitle C—Tax Equity for Health Plan Beneficiaries

SEC. 9031. APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.

(a) EXCLUSION OF CONTRIBUTIONS.—Section 106 of the Internal Revenue Code of 1986, as amended by section 9003, is amended by adding at the end the following new subsection:

''(g) COVERAGE PROVIDED FOR ELIGIBLE BENEFICIARIES OF EMPLOYEES.—

''(1) IN GENERAL.—Subsection (a) shall apply with respect to any eligible beneficiary of the employee.

''(2) ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'eligible beneficiary' means any individual who is eligible to receive benefits or coverage under an accident or health plan.''.

(b) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of section 105(b) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''and his dependents'' and inserting ''his dependents'', and

(2) by inserting before the period the following: ''and any eligible beneficiary (within the meaning of section 106(g)) with respect to the taxpayer''.

(c) PAYROLL TAXES.—

(1) Section 3121(a)(2) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'',

(B) by striking ''or any of his dependents,'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(C) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(2) Section 3231(e)(1) of such Code is amended—

(A) by striking ''or any of his dependents'' and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'', and

(B) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(3) Section 3306(b)(2) of such Code is amended—

(A) by striking ''or any of his dependents'' in the matter preceding subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee,'',

(B) by striking ''or any of his dependents'' in subparagraph (A) and inserting '', any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee'', and

(C) by striking ''and their dependents'' both places it appears and inserting ''and such employees' dependents and eligible beneficiaries (within the meaning of section 106(g))''.

(4) Section 3401(a) of such Code is amended by striking ''or'' at the end of paragraph (22), by striking the period at the end of paragraph (23) and inserting ''; or'', and by inserting after paragraph (23) the following new paragraph:

''(24) for any payment made to or for the benefit of an employee or any eligible beneficiary (within the meaning of section 106(g)) if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106 or under section 105 by reference in section 105(b) to section 106(g).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9032. EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

''(A) the taxpayer,

''(B) the taxpayer's spouse,

''(C) the taxpayer's dependents, and

''(D) any individual who—

''(i) satisfies the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

''(iii) meets the requirements of section 152(d)(1)(C), and

''(E) not more than one individual who—

''(i) does not satisfy the age requirements of section 152(c)(3)(A),

''(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H),

''(iii) meets the requirements of section 152(d)(1)(D), and

''(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2).''.

(b) CONFORMING AMENDMENT.—Subparagraph (B) of section 162(l)(2) of the Internal Revenue Code of 1986 is amended by inserting '', any dependent, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to'' after ''spouse''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9033. EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS OF A VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.

(a) IN GENERAL.—Section 501(c)(9) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term 'dependents' shall include any individual who is an eligible beneficiary (within the meaning of section 106(g)), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9034. FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.

The Secretary of Treasury shall issue guidance of general applicability providing that medical expenses that otherwise qualify—

(1) for reimbursement from a flexible spending arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's flexible spending arrangement, notwithstanding the fact that such expenses are attributable to any individual who is not the employee's spouse or dependent (within the meaning of section 105(b) of the Internal Revenue Code of 1986) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the flexible spending arrangement with respect to the employee, and

(2) for reimbursement from a health reimbursement arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee's health reimbursement arrangement, notwithstanding the fact that such expenses are attributable to an individual who is not a spouse or dependent (within the meaning of section 105(b) of such Code) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the health reimbursement arrangement with respect to the employee.

SA 2995. Mr. SCHUMER (for himself and Ms. MIKULSKI) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 466, between lines 5 and 6, insert the following:

SEC. 2305. REQUIRING COVERAGE OF SERVICES OF PODIATRISTS.

(a) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1) and (3) of section 1861(r)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) DELAY IF NEEDED FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SA 2996. Mr. KOHL (for himself, Mr. WYDEN, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed

to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1979, between lines 15 and 16, insert the following:

Subtitle B—Long-Term Care Insurance

PART I—NATIONAL MARKET SURVEY; MODEL DISCLOSURES AND DEFINITIONS; LTC INSURANCE COMPARE

SEC. 8101. NAIC NATIONAL MARKET SURVEY.

(a) IN GENERAL.—The Secretary shall request the NAIC to conduct reviews of the national and State-specific markets for long-term care insurance policies and to submit reports to the Secretary on the results of such reviews every 5 years.

(b) CONTENT.—The Secretary shall request that the reviews include, with respect to the period occurring since any prior review, analysis of the following:

(1) Information on key market parameters, including the number of carriers offering long-term care insurance, and the scope of coverage offered under those policies (such as policies offering nursing-home only benefits, policies offering comprehensive coverage, cash plans, and reimbursement plans, and hybrid products in which long-term care benefits are present).

(2) The number of complaints received and resolved, including benefit denials.

(3) The number of policies that have lapsed.

(4) The number of agents trained and whether the training included competency tests.

(5) The number of policyholders exhausting benefits.

(6) The number of premium rate increases filed by carriers on a policy basis with the States, including the ranges of the increases approved for or finally used.

(7) The number of policyholders affected by any premium rate increases.

(8) Requests for exceptions to State permitted accounting practices, as defined by the NAIC.

(c) TIMING FOR REVIEWS AND REPORTS.—The Secretary shall request the NAIC to—

(1) complete the initial market review under this section not later than 2 years after the date of enactment of this Act;

(2) submit a report to the Secretary on the results of the initial review not later than December 31, 2011; and

(3) complete each subsequent review and submit each subsequent report not later than December 31 of the fifth succeeding year.

(d) CONSULTATION REQUIRED.—The Secretary shall request the NAIC to consult with State insurance commissioners, appropriate Federal agencies, issuers of long-term care insurance, States with experience in long-term care insurance partnership plans, other States, representatives of consumer groups, consumers of long-term care insurance policies, and such other stakeholders as the Secretary or the NAIC determine appropriate, to conduct the market reviews requested under this section.

(e) DEFINITIONS.—In this section and section 8102:

(1) LONG-TERM CARE INSURANCE POLICY.—The term ''long-term care insurance policy''—

(A) means—

(i) a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986); and

(ii) a qualified long-term care insurance contract that covers an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section; and

(B) includes any other insurance policy or rider described in the definition of ''long-term care insurance'' in section 4 of the model Act promulgated by the National Association of Insurance Commissioners (as adopted December 2006).

(2) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 8102. MODEL DISCLOSURE FORM.

(a) NAIC STUDY AND REPORT ON STATE DISCLOSURE REQUIREMENTS FOR LONG-TERM CARE INSURANCE.—

(1) IN GENERAL.—The Secretary shall request the NAIC to carry out the activities described in paragraph (2) and issue the report described in paragraph (3).

(2) REVIEW AND DEVELOPMENT OF PROPOSED MODEL DISCLOSURE REQUIREMENTS.—The activities described in this paragraph are the following:

(A) MODEL ACT AND REGULATION DISCLOSURE REQUIREMENTS.—Review and describe disclosure requirements for long-term care insurance policies under the Model Act and regulation.

(B) STATE LAW DISCLOSURE REQUIREMENTS.—Review and describe disclosure requirements for long-term care insurance policies under State laws, including as part of such description an analysis of the effectiveness of the various existing disclosures.

(C) LONG-TERM CARE SERVICES.—Review and describe differences in long-term care services, including with respect to providers of such services and the settings in which such services are provided among States and develop standardized definitions for long-term care services.

(D) IDENTIFICATION OF KEY ISSUES FOR DEVELOPMENT OF MODEL DISCLOSURE MARKETING FORM.—Identify and describe key issues to consider in the development of a proposed form for marketing long-term care insurance policies.

(3) REPORT.—The report described in this paragraph is an NAIC White Paper that is issued not later than 12 months after the date of enactment of this Act and contains the results of the reviews conducted under paragraph (2) and the descriptions required under that paragraph.

(b) NAIC WORKING GROUP TO DEVELOP MODEL DISCLOSURE FORM FOR LONG-TERM CARE INSURANCE.—

(1) IN GENERAL.—The Secretary shall request the NAIC to establish, not later than 60 days after the date on which the NAIC White Paper described in subsection (a)(3) is issued and in consultation with the Secretary and the Secretary of the Treasury, a Working Group to develop a model disclosure form for marketing long-term care insurance policies.

(2) WORKING GROUP MEMBERS.—The Working Group established under paragraph (1) shall be composed of the following:

(A) Representatives from State Departments of Health (or the most appropriate State agencies with responsibility for oversight of the provision of long-term care).

(B) Representatives of long-term care providers and facilities.

(C) Consumer advocates.

(D) Representatives of issuers of long-term care insurance policies.

(E) Representatives of the NAIC or State insurance commissioners.

(F) Other experts in long-term care and long-term care insurance policies selected by the Secretary and Secretary of the Treasury or the NAIC.

(3) REQUIREMENTS FOR DEVELOPMENT OF FORM.—

(A) CONSIDERATIONS.—In developing the model form, the Working Group shall consider the following:

(i) Variations among providers, services, and facilities in the long-term care and long-term care insurance markets.

(ii) The results of the reviews and the descriptions included in the NAIC White Paper issued under subsection (a)(3).

(iii) Such other information and factors as the Working Group determines appropriate.

(B) MINIMUM STANDARDS.—The Working Group shall ensure that the model has—

(i) minimum standard definitions for coverage of the various types of services and benefits provided under long-term care insurance policies;

(ii) minimum standard language for use by issuers of such policies, and for agents selling such policies, in explaining the services and benefits covered under the policies and restrictions on the services and benefits;

(iii) minimum standard format, color and type size for disclosure documents; and

(iv) such other minimum standards as the Working Group determines appropriate.

(4) DEADLINE FOR DEVELOPMENT.—The Working Group shall issue a proposed model disclosure form for marketing long-term care insurance policies not later than 1 year after the date on which the Working Group is established.

(5) ADOPTION AND INCORPORATION INTO MODEL ACT AND REGULATION.—The Secretary shall request the NAIC to amend the Model Act and regulation to incorporate the use of the proposed model disclosure form issued by the Working Group, not later than 1 year after the date on which the Working Group issues the form.

(c) REQUIRED USE OF MODEL DISCLOSURE FORM IN MARKETING LONG-TERM CARE INSURANCE POLICIES.—

(1) APPLICATION TO TAX-QUALIFIED AND MEDICAID PARTNERSHIP POLICIES.—Not later than 1 year after the date on which the Working Group issues the proposed model disclosure form for marketing long-term care insurance policies under subsection (b):

(A) TAX-QUALIFIED POLICIES.—The Secretary of the Treasury shall promulgate a regulation requiring, not later than 1 year after the date on which the regulation is final, any issuer of a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986) to use the proposed model disclosure form for marketing such contracts, to the extent such disclosure is not inconsistent with State law.

(B) MEDICAID PARTNERSHIP POLICIES.—The Secretary shall promulgate a regulation requiring, not later than 1 year after the date on which the regulation is final, any issuer that markets a qualified long-term care insurance contract intended to cover an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section to use the proposed model disclosure form for marketing such contracts.

(2) APPLICATION TO ALL OTHER LONG-TERM CARE INSURANCE POLICIES.—Not later than 18 months, or the earliest date on which an amendment could be enacted for those

States with legislatures which meet only every other year, after the date on which the NAIC adopts an amended Model Act and regulation to require the use of the proposed model disclosure form issued by the Working Group under subsection (b), each State shall require by statute or regulation any issuer of a long-term care insurance policy to use the proposed model disclosure form when marketing such a policy in the State.

SEC. 8103. LTC INSURANCE COMPARE.

(a) IN GENERAL.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)—

(i) in clause (ii), by striking ''and'' at the end;

(ii) in clause (iii), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(iv) establish an Internet directory of information regarding long-term care insurance, to be known as 'LTC Insurance Compare', that shall include the following:

''(I) Comparison tools to assist consumers in evaluating long-term care insurance policies (as defined in subparagraph (D)) with different benefits and features and that allow consumers to compare the price, long-term premium stability, and carrier financial strength of such policies.

''(II) State-specific information about the long-term care insurance policies marketed in a State, including the following:

''(aa) Whether a State has promulgated rate stability provisions or has rate stability procedures in place, and how the standards or procedures work.

''(bb) The rating history for at least the most recent preceding 5 years for issuers selling long-term care insurance policies in the State.

''(cc) An appropriate sampling of the policy forms marketed in the State.

''(III) Links to State information regarding long-term care under State Medicaid programs (which may be provided, as appropriate, through Internet linkages to the websites of State Medicaid programs) that includes the following:

''(aa) The medical assistance provided under each State's Medicaid program for nursing facility services and other long-term care services (including any functional criteria imposed for receipt of such services, as reported in accordance with section 1902(a)(28)(D) of the Social Security Act) and any differences from benefits and services offered under long-term care insurance policies in the State and the criteria for triggering receipt of such benefits and services.

''(bb) If the State has a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of the Social Security Act, information regarding how and when an individual with a partnership long-term care insurance policy who is receiving benefits under the policy should apply for medical assistance for nursing facility services or other long-term care services under the State Medicaid program and information regarding about how Medicaid asset protection is accumulated over time.''; and

(B) by adding at the end the following:

''(C) CURRENT INFORMATION.—The Secretary of Health and Human Services shall ensure that, to the greatest extent practicable, the information maintained in the National Clearinghouse for Long-Term Care Information, including the information required for LTC Insurance Compare, is the most recent information available.

''(D) LONG-TERM CARE INSURANCE POLICY DEFINED.—In subparagraph (A)(iv), the term 'long-term care insurance policy' means a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986), a qualified long-term care insurance contract that covers an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section, and includes any other insurance policy or rider described in the definition of 'long-term care insurance' in section 4 of the model Act promulgated by the National Association of Insurance Commissioners (as adopted December 2006).'';

(2) by redesignating paragraph (3) as paragraph (4); and

(3) by inserting after paragraph (2) the following:

''(3) CONSULTATION ON LTC INSURANCE COMPARE.—The Secretary of Health and Human Services shall consult with the National Association of Insurance Commissioners and the entities and stakeholders specified in section 8101(d) of the Patient Protection and Affordable Care Act in designing and implementing the LTC Insurance Compare required under paragraph (2)(A)(iv).''.

(b) MEDICAID STATE PLAN REQUIREMENT TO SUBMIT NURSING FACILITY SERVICES FUNCTIONAL CRITERIA DATA.—Section 1902(a)(28) of the Social Security Act (42 U.S.C. 1396a(a)(28)) is amended—

(1) in subparagraph (C), by striking ''and'' after the semicolon;

(2) in subparagraph (D)(iii), by adding ''and'' after the semicolon; and

(3) by inserting after subparagraph (D)(iii), the following new subparagraph:

''(E) for the annual submission of data relating to functional criteria for the receipt of nursing facility services under the plan (in such form and manner as the Secretary shall specify);''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation or State regulation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

PART II—IMPROVED STATE CONSUMER PROTECTIONS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS AND MEDICAID PARTNERSHIP POLICIES

SEC. 8121. APPLICATION OF MEDICAID PARTNERSHIP REQUIRED MODEL PROVISIONS TO ALL TAX-QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Section 7702B(g)(1) of the Internal Revenue Code of 1986 (relating to consumer protection provisions) is amended—

(1) in subparagraph (A), by inserting ''(but only to the extent such requirements do not conflict with requirements applicable under subparagraph (B)),'' after ''paragraph (2)'',

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), respectively, and

(3) by inserting after subparagraph (A), the following new subparagraph:

''(B) the requirements of the model regulation and model Act described in section 1917(b)(5) of the Social Security Act,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contracts issued on or after the date that is 1 year after the date of enactment of this Act.

SEC. 8122. STREAMLINED PROCESS FOR APPLYING NEW OR UPDATED MODEL PROVISIONS.

(a) SECRETARIAL REVIEW.—

(1) TAX-QUALIFIED POLICIES.—

(A) 2000 AND 2006 MODEL PROVISIONS.—Not later than 12 months after the date of enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall review the model provisions specified in subsection (c)(1) for purposes of determining whether updating any such provisions for a provision specified in section 7702B(g)(2) of the Internal Revenue Code of 1986, or the inclusion of any such provisions in such section, for purposes of an insurance contract qualifying for treatment as a qualified long-term care insurance contract under such Code, would improve consumer protections for insured individuals under such contracts.

(B) SUBSEQUENT MODEL PROVISIONS.—Not later than 12 months after model provisions described in paragraph (2) or (3) of subsection (c) are adopted by the National Association of Insurance Commissioners, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall review the model provisions to determine whether the application of such provisions to an insurance contract for purposes of qualifying for treatment as a qualified long-term care insurance contract under section 7702B(g)(2) of the Internal Revenue Code of 1986, would improve consumer protections for insured individuals under such contracts.

(2) MEDICAID PARTNERSHIP POLICIES.—

(A) SUBSEQUENT MODEL PROVISIONS.—Not later than 12 months after model provisions described in paragraph (2) or (3) of subsection (c) are adopted by the National Association of Insurance Commissioners, the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall review the model provisions to determine whether the application of such provisions to an insurance contract for purposes of satisfying the requirements for participation in a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act (42 U.S.C. 1396p(b)(1)(C)(iii)) would improve consumer protections for insured individuals under such contracts.

(B) REVIEW OF OTHER PARTNERSHIP REQUIREMENTS.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall review clauses (iii) and (iv) of section 1917(b)(1)(C) for purposes of determining whether the requirements specified in such clauses should be modified to provide improved consumer protections or, as appropriate, to resolve any conflicts with the application of the 2006 model provisions under paragraph (5) of section 1917(b) (as amended by section 302(a)) or with the application of any model provisions that the Secretary determines should apply to an insurance contract as a result of a review required under subparagraph (A).

(b) EXPEDITED RULEMAKING.—

(1) TAX-QUALIFIED POLICIES.—Subject to paragraph (3), if the Secretary of the Treasury determines that any model provisions reviewed under subsection (a)(1) should apply

for purposes of an insurance contract qualifying for treatment as a qualified long-term care insurance contract under the Internal Revenue Code of 1986, the Secretary shall promulgate an interim final rule applying such provisions for such purposes not later than 3 months after making such determination.

(2) MEDICAID PARTNERSHIP POLICIES.—Subject to paragraph (3), if the Secretary of Health and Human Services determines that any model provisions or requirements reviewed under subsection (a)(2) should apply for purposes of an insurance contract satisfying the requirements for participation in a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act (42 U.S.C. 1396p(b)(1)(C)(iii)), the Secretary shall promulgate an interim final rule applying such provisions for such purposes not later than 3 months after making such determination.

(3) CONSULTATION REQUIRED.—The Secretary of the Treasury and the Secretary of Health and Human Services, respectively, shall consult with the National Association of Insurance Commissioners and the entities and stakeholders specified in section 101(d) regarding the extent to which it is appropriate to apply the model provisions described in paragraph (1) or (2) (as applicable) to insurance contracts described in such paragraphs through promulgation of an interim final rule. If, after such consultation—

(A) the Secretary of the Treasury determines it would be appropriate to promulgate an interim final rule, the Secretary of the Treasury shall use notice and comment rulemaking to promulgate a rule applying such provisions to insurance contracts described in paragraph (1); and

(B) the Secretary of Health and Human Services determines it would be appropriate to promulgate an interim final rule, the Secretary of Health and Human Services shall use notice and comment rulemaking to promulgate a rule applying such provisions to insurance contracts described in paragraph (2).

(4) RULE OF CONSTRUCTION RELATING TO APPLICATION OF CONGRESSIONAL REVIEW ACT.—Nothing in paragraphs (1), (2), or (3) shall be construed as affecting the application of the sections 801 through 808 of title 5, United States Code (commonly known as the ''Congressional Review Act'') to any interim final rule issued in accordance with such paragraphs.

(5) TECHNICAL AMENDMENT ELIMINATING PRIOR REVIEW STANDARD MADE OBSOLETE.—Section 1917(b)(5) of the Social Security Act (42 U.S.C. 1396p(b)(5)) is amended by striking subparagraph (C).

(c) MODEL PROVISIONS.—In this section, the term ''model provisions'' means—

(1) each provision of the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000 and as of December 2006);

(2) each provision of the model language relating to marketing disclosures and definitions developed under section 102(b)(1); and

(3) each provision of any long-term care insurance model regulation, or the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners and adopted after December 2006.

PART III—IMPROVED CONSUMER PROTECTIONS FOR MEDICAID PARTNERSHIP POLICIES

SEC. 8131. BIENNIAL REPORTS ON IMPACT OF MEDICAID LONG-TERM CARE INSURANCE PARTNERSHIPS.

Section 6021(c) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended to read as follows:

''(c) BIENNIAL REPORTS.—

''(1) IN GENERAL.—Not later than January 1, 2011, and biennially thereafter, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall issue a report to States and Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)). Each report shall include (with respect to the period the report addresses) the following information, nationally and on a State-specific basis:

''(A) Analyses of the extent to which such partnerships improve access of individuals to affordable long-term care services and benefits and the impact of such partnerships on Federal and State expenditures on long-term care under the Medicare and Medicaid programs.

''(B) Analyses of the impact of such partnerships on consumer decisionmaking with respect to purchasing, accessing, and retaining coverage under long-term care insurance policies (as defined in subsection (d)(2)(D)), including a description of the benefits and services offered under such policies, the average premiums for coverage under such policies, the number of policies sold and at what ages, the number of policies retained and for how long, the number of policies for which coverage was exhausted, and the number of insured individuals who were determined eligible for medical assistance under the State Medicaid program.

''(2) DATA.—The reports by issuers of partnership long-term care insurance policies required under section 1917(b)(1)(C)(iii)(VI) of the Social Security Act shall include such data as the Secretary shall specify in order to conduct the analyses required under paragraph (1).

''(3) PUBLIC AVAILABILITY.—The Secretary shall make each report issued under this subsection publicly available through the LTC Insurance Compare website required under subsection (d).

''(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.''.

SEC. 8132. ADDITIONAL CONSUMER PROTECTIONS FOR MEDICAID PARTNERSHIPS.

(a) APPLICATION OF 2006 MODEL PROVISIONS.—

(1) UPDATING OF 2000 REQUIREMENTS.—

(A) IN GENERAL.—Section 1917(b)(5)(B)(i) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(i)) is amended by striking ''October 2000'' and inserting ''December 2006''.

(B) CONFORMING AMENDMENTS.—

(i) Subclause (XVII) of such section is amended by striking ''section 26'' and inserting ''section 28''.

(ii) Subclause (XVIII) of such section is amended by striking ''section 29'' and inserting ''section 31''.

(iii) Subclause (XIX) of such section is amended by striking ''section 30'' and inserting ''section 32''.

(2) APPLICATION TO GRANDFATHERED PARTNERSHIPS.—Section 1917(b)(1)(C)(iv) of such Act (42 U.S.C. 1396p(b)(1)(C)(iv)) is amended by inserting '', and the State satisfies the requirements of paragraph (5)'' after ''2005''.

(b) APPLICATION OF PRODUCER TRAINING MODEL ACT REQUIREMENTS.—Section 1917(b)(1)(C) of such Act (42 U.S.C. 1396p(b)(1)(C)) is amended—

(1) in clause (iii)(V), by inserting ''and satisfies the producer training requirements specified in section 9 of the model Act specified in paragraph (5)'' after ''coverage of long-term care''; and

(2) in clause (iv), as amended by subsection (a)(2), by inserting ''clause (iii)(V) and'' before ''paragraph (5)''.

(c) APPLICATION OF ADDITIONAL REQUIREMENTS FOR ALL PARTNERSHIPS.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1)(C)—

(A) in clause (iii)—

(i) by inserting after subclause (VII) the following new subclause:

''(VIII) The State satisfies the requirements of paragraph (6).''; and

(ii) in the flush sentence at the end, by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

(B) in clause (iv), as amended by subsections (a)(2) and (b)(2), by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

(2) by adding at the end the following new paragraph:

''(6) For purposes of clauses (iii)(VIII) and (iv) of paragraph (1)(C), the requirements of this paragraph are the following:

''(A) The State requires issuers of long-term care insurance policies to—

''(i) use marketing materials filed with the State for purposes of the partnership in all sales and marketing activities conducted or supported by the issuers in the State with respect to any long-term care insurance policies marketed by the issuer in the State;

''(ii) provide such materials to all agents selling long-term care insurance policies in the State;

''(iii) ensure that agent training and education courses conducted or supported by the issuers incorporate discussion of marketing materials; and

''(iv) make such materials available to any consumer upon request, and to make such materials available to all prospective purchasers of a policy offered under a qualified State long-term care insurance partnership before submission of an application for coverage under that policy.

''(B) The State requires issuers of long-term care insurance policies sold in the State to require agents to use any inflation protection comparison form developed by the National Association of Insurance Commissioners when selling the policies in the State.

''(C) The State requires issuers of long-term care insurance policies sold in the State to comply with the provisions of section 8 of the model Act specified in paragraph (5) relating to contingent nonforfeiture benefits.

''(D) The State enacts legislation, not later than January 1, 2012, that establishes rating standards for all issuers of long-term care insurance policies sold in the State that result in rates over the life of the policy that are no less protective of consumers than those produced by the premium rate schedule increase standards specified in section 20 of the model regulation specified in paragraph (5), unless the State has more stringent procedures or requirements.

''(E) The State develops and updates marketing materials filed with the State whenever changes are made under the State plan that relate to eligibility for medical assistance for nursing facility services, including other long-term care services or the amount, duration, or scope of medical assistance for nursing facility services, and also provides to

individuals at the time of application for medical assistance under the State plan, or under a waiver of the plan materials that describe in clear, simple language the terms of eligibility, the benefits and services provided as such assistance, and rules relating to adjustment or recovery from the estate of an individual who receives such assistance. Such materials shall include a clear disclosure that medical assistance is not guaranteed to partnership policyholders who exhaust benefits under a partnership policy, and that Federal changes to the program under this title or State changes to the State plan may affect an individual's eligibility for, or receipt of, such assistance.

''(F) The State—

''(i) through the State Medicaid agency under section 1902(a)(5) and in consultation with the State insurance department, develops materials explaining how the benefits and rules of long-term care policies offered by issuers participating in the partnership interact with the benefits and rules under the State plan under this title;

''(ii) requires agents to use such materials when selling or otherwise discussing how long-term care policies offered by issuers participating in the partnership work with potential purchasers and to provide the materials to any such purchasers upon request;

''(iii) informs holders of such policies of any changes in eligibility requirements under the State plan under this title and of any changes in estate recovery rules under the State plan as soon as practicable after such changes are made at the time or at the time of application for medical assistance; and

''(iv) agrees to honor the asset protections of any such policy that were provided under the policy when purchased, regardless of whether the State subsequently terminates a partnership program under the State plan.

''(G) The State Medicaid agency under section 1902(a)(5) and the State insurance department enter into a memorandum of understanding to—

''(i) inform consumers about long-term care policies offered by issuers participating in the partnership, the amount, duration, or scope of medical assistance for nursing facility services or other long-term care services offered under the State plan, consumer protections, and any other issues such agency and department determine appropriate through such means as the State determines appropriate; and

''(ii) jointly facilitate coordination in eligibility determinations for medical assistance under the State plan and the provision of benefits or other services under such policies and medical assistance provided under the State plan that includes—

''(I) the number of policyholders applying for medical assistance under the State plan; and

''(II) the number of policyholders deemed eligible (and, if applicable, ineligible) for such assistance.

''(H) Subject to subparagraph (I), the State enters into agreements with other States that have established qualified State long-term care insurance partnerships under which such States agree to provide reciprocity for policyholders under such partnerships, including providing guaranteed asset protection to all individuals covered under a policy offered under a qualified State long-term care insurance partnership who bought such a policy in the State or in another State with such a partnership and with which the State has a reciprocity agreement.

''(I)(i) In the case of a State described in paragraph (1)(C)(iv) (in this subparagraph referred to as a 'grandfathered partnership State') —

''(I) the grandfathered partnership State may, in lieu of entering into agreements that satisfy subparagraph (I), enter into individual reciprocity agreements with other States that have established qualified State long-term care insurance partnerships; and

''(II) if the grandfathered partnership State has not, as of January 1, 2013, entered into a reciprocity agreement with each State that has a qualified State long-term care insurance partnership, the grandfathered partnership State shall enter into and comply with a reciprocity agreement developed by the Secretary in accordance with clause (ii) for each partnership State that the grandfathered State does not have a reciprocity agreement with and, with respect to each such State, for so long as the grandfathered partnership State does not have an individual reciprocity agreement with that State.

''(ii) In developing a reciprocity agreement for purposes of clause (i)(II), the Secretary shall take into account—

''(I) the difference in consumer protections under the partnership program of the grandfathered partnership State and the other partnership State that will be covered by the agreement, and, to the greatest extent possible, preserve the more protective requirements; and

''(II) the impact the reciprocity agreement will have on expenditures under the State plan under this title (including under any waivers of such plan) of each such State and, to the greatest extent possible, minimize any negative impact on such expenditures and States.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date that is 1 year after the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 8133. REPORT TO CONGRESS REGARDING NEED FOR MINIMUM ANNUAL COMPOUND INFLATION PROTECTION.

Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit a report to Congress that includes the Secretary's recommendation regarding whether legislative or other administrative action should be taken to require all long-term care insurance policies sold after a date determined by the Secretary in connection with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section, provide a minimum level of annual compound inflation protection, and if so, whether such requirements should be imposed on a basis related to the age of the policyholder at the time of purchase. The Secretary shall include in the report information on the various levels of inflation protection available under such long-term care insurance partnerships and the methodologies used by issuers of such policies to calculate and present various inflation protection options under such policies, including policies with a future purchase option feature.

PART IV—PRESERVATION OF STATE AUTHORITY

SEC. 8141. PRESERVATION OF STATE AUTHORITY.

Nothing in this title, any amendments made by this title, or any rules promulgated to carry out this title or such amendments, shall be construed to limit the authority of a State to enact, adopt, promulgate, and enforce any law, rule, regulation, or other measure with respect to long-term care insurance that is in addition to, or more stringent than, requirements established under this title and the amendments made by this title.

SA 2997. Ms. KLOBUCHAR (for herself, Mr. BROWN, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1441, line 5, strike ''or pediatric medicine'' and insert ''neurology, or pediatric medicine''.

SA 2998. Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. PROVIDER AND SUPPLIER PAYMENTS UNDER MEDICARE AND MEDICAID THROUGH DIRECT DEPOSIT OR ELECTRONIC FUNDS TRANSFER (EFT) AT INSURED DEPOSITORY INSTITUTIONS.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(i) LIMITATION ON PAYMENT TO PROVIDERS OF SERVICES AND SUPPLIERS.—No payment shall be made under this title for items and services furnished by a provider of services or supplier unless each payment to the provider of services or supplier is in the form of direct deposit or electronic funds transfer to the provider of services' or supplier's account, as applicable, at a depository institution (as defined in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A))).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to each payment made to a provider of services, provider, or supplier on or after such date (not later than July 1, 2012) as the Secretary of

Health and Human Services shall specify, regardless of when the items and services for which such payment is made were furnished.

(b) MEDICAID PILOT PROJECT.—

(1) AUTHORITY TO ESTABLISH.—The Secretary shall establish a Medicaid pilot project under which payment for items and services furnished by providers or suppliers of items or services under the Medicaid programs of the States selected to participate in the project is in the form of a direct deposit or electronic funds transfer to the provider's or supplier's account, as applicable, at a depository institution (as defined in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A))).

(2) DEADLINE FOR IMPLEMENTATION.—The pilot project established under paragraph (1) shall begin in fiscal year 2012.

(3) REPORT.—Not later than September 30, 2014, the Secretary of Health and Human Services shall report to Congress on the pilot project established under this subsection. The report shall include an analysis of the extent to which the project is effective in improving efficiency, reducing administrative costs, and preventing fraud in the Medicaid program and a recommendation as to whether the project should be expanded to additional or all State Medicaid programs.

SA 2999. Ms. SNOWE (for herself, Mr. KERRY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2057, between lines 6 and 7, insert the following:

SEC. ___. APPLICATION OF CAFETERIA PLANS TO SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—

(1) APPLICATION TO SELF-EMPLOYED INDIVIDUALS.—Section 125(d) of the Internal Revenue Code of 1986 (defining cafeteria plan) is amended by adding at the end the following new paragraph:

''(3) EMPLOYEE TO INCLUDE SELF-EMPLOYED.—

''(A) IN GENERAL.—The term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(B) LIMITATIONS.—

''(i) IN GENERAL.—The amount which may be excluded under subsection (a) with respect to a participant in a cafeteria plan by reason of being an employee under subparagraph (A) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the cafeteria plan is established.

''(ii) LIMITATIONS ON CERTAIN FLEXIBLE SPENDING ARRANGEMENTS.—No amount shall be excluded under subsection (a) with respect to any plan which provides benefits in the form of a health flexible spending arrangement or a dependent care flexible spending arrangement and in which an individual described in subparagraph (A) participates unless such plan is administered by a person other than the employer.

''(C) ADDITIONAL TAX ON UNREIMBURSED AMOUNTS.—

''(i) IN GENERAL.—The tax imposed by this chapter on any person who is described in subparagraph (A) and who is a participant in a cafeteria plan which provides benefits in the form of a health flexible spending arrangement or a dependent care flexible spending arrangement shall be increased by an amount equal to 100 percent of the excess (if any) of—

''(I) the maximum value of the qualified benefit with respect to such person, over

''(II) the amount of covered expenses both incurred during the coverage period for the qualified benefit, and any grace period, and reimbursed during that period or during any appropriate run-out period.

''(ii) COLLECTION.—The tax imposed by this subparagraph shall be collected by the person administering the flexible spending arrangement, and to the extent that such person fails to collect such tax, the tax shall be paid by such person.''.

(2) APPLICATION TO BENEFITS WHICH MAY BE PROVIDED UNDER CAFETERIA PLAN.—

(A) GROUP-TERM LIFE INSURANCE.—Section 79 of the Internal Revenue Code of 1986 (relating to group-term life insurance provided to employees) is amended by adding at the end the following new subsection:

''(f) EMPLOYEE INCLUDES SELF-EMPLOYED.—

''(1) IN GENERAL.—For purposes of this section, the term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(2) LIMITATION.—The amount which may be excluded under the exceptions contained in subsection (a) or (b) with respect to an individual treated as an employee by reason of paragraph (1) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the individual is so treated.''.

(B) ACCIDENT AND HEALTH PLANS.—Subsection (g) of section 105 of such Code (relating to amounts received under accident and health plans) is amended to read as follows:

''(g) EMPLOYEE INCLUDES SELF-EMPLOYED.—

''(1) IN GENERAL.—For purposes of this section, in the case of any coverage under an accident or health plan which is provided through a simple cafeteria plan under section 125(j), the term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(2) LIMITATION.—The amount which may be excluded under this section by reason of subsection (b) or (c) with respect to an individual treated as an employee by reason of paragraph (1) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the accident or health insurance was established.''.

(C) CONTRIBUTIONS BY EMPLOYERS TO ACCIDENT AND HEALTH PLANS.—

(i) IN GENERAL.—Section 106 of such Code is amended by inserting after subsection (e) the following new subsection:

''(f) SPECIAL RULE FOR BENEFITS PROVIDED THROUGH SIMPLE CAFETERIA PLANS.—

''(1) IN GENERAL.—For purposes of this section, in the case of any coverage under an accident or health plan which is provided through a simple cafeteria plan under section 125(j), the term 'employee' includes an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

''(2) LIMITATION.—The amount which may be excluded under subsection (a) with respect to an individual treated as an employee by reason of paragraph (1) shall not exceed the employee's earned income (within the meaning of section 401(c)) derived from the trade or business with respect to which the accident or health insurance was established.''.

(ii) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of such Code is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 3000. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title VI insert the following:

SEC. 6303. PROHIBITION ON COMPARATIVE EFFECTIVENESS RESEARCH FOR THE PURPOSE OF DETERMINING COST AND COVERAGE DECISIONS.

Reports and recommendations from the Patient-Centered Outcomes Research Institute, established under section 1181 of the Social Security Act (as added by section 6301), or any other government entity are prohibited from being used by any government entity for payment, coverage, or treatment decisions based on costs. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of such Institute or other government entity when making decisions about the best treatment for an individual patient in an individual circumstance.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Wednesday, December 9, 2009, at 9:30 a.m. in room 628 of the Dirksen Senate Office Building to conduct a business meeting on pending committee issues, to be followed immediately by a legislative hearing on S. 1690, a bill to amend the Act of March 1, 1933, to transfer certain authority and resources to the Utah Dineh Corporation, and for other purposes. The Committee will then conduct a hearing entitled ''Where's the Trustee? U.S. Department of the Interior Backlogs Prevent Tribes from Using their Lands.''

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

EXECUTIVE SESSION

NOMINATIONS DISCHARGED

Mr. BROWN. Madam President, I ask unanimous consent the Senate proceed to executive session and the Foreign Relations Committee be discharged en bloc from PN1001, PN1002, PN1003, PN1005, PN1016; and then the Senate

proceed en bloc to the consideration of the nominations; that the nominations be confirmed en bloc; the motions to reconsider be considered made and laid upon the table en bloc; that no further motions be in order, and any statements relating to the nominations be printed in the RECORD; the President be immediately notified of the Senate's action and the Senate then resume legislative session.

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

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF STATE

Bill Delahunt, of Massachusetts, to be a Representative of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations.

Elaine Schuster, of Florida, to be a Representative of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations.

Christopher H. Smith, of New Jersey, to be a Representative of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations.

Wellington E. Webb, of Colorado, to be an Alternate Representative of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations.

Laura Gore Ross, of New York, to be an Alternate Representative of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate resumes legislative session.

ORDERS FOR TUESDAY, DECEMBER 8, 2009

Mr. BROWN. I ask unanimous consent when the Senate completes its business today, it adjourn until 10 a.m., Tuesday, December 8; that following the prayer and pledge, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of S. 3590, the health care reform legislation; that following leader remarks, the time until 12:30 p.m. be for debate only, with the time equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each, with the majority controlling the first hour and the Republicans controlling the next hour; finally, I ask that the Senate recess from 12:30 until 2:15 to allow for the weekly caucus luncheons.

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

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. BROWN. If there is no further business to come before the Senate, I ask unanimous consent it adjourn under the previous order.

There being no objection, the Senate, at 6:39 p.m., adjourned until Tuesday, December 8, 2009, at 10 a.m.

DISCHARGED NOMINATIONS

The Senate Committee on Foreign Relations was discharged from further consideration of the following nominations by unanimous consent and the nominations were confirmed:

BILL DELAHUNT, OF MASSACHUSETTS, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

ELAINE SCHUSTER, OF FLORIDA, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

CHRISTOPHER H. SMITH, OF NEW JERSEY, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

WELLINGTON E. WEBB, OF COLORADO, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

LAURA GORE ROSS, OF NEW YORK, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

CONFIRMATIONS

Executive nominations confirmed by the Senate, Monday, December 7, 2009:

DEPARTMENT OF STATE

BILL DELAHUNT, OF MASSACHUSETTS, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

ELAINE SCHUSTER, OF FLORIDA, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

CHRISTOPHER H. SMITH, OF NEW JERSEY, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

WELLINGTON E. WEBB, OF COLORADO, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

LAURA GORE ROSS, OF NEW YORK, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SIXTY-FOURTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.