United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

Vol. 155 WASHINGTON, MONDAY, NOVEMBER 30, 2009 No. 175

House of Representatives

The House was not in session today. Its next meeting will be held on Tuesday, December 1, 2009, at 2 p.m.

Senate

MONDAY, NOVEMBER 30, 2009

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

PRAYER

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

Let us pray:

O God, the hope of all the ends of the Earth be in our midst today. Endue our lawmakers with a spirit of wisdom that will bring peace and prosperity within our borders. Lord, keep them from disunity, ignited by selfish fires, that will hinder Your purposes in our world. Pardon and overrule what has been left undone or done amiss as You strengthen all that has been worthily achieved. Bless and keep us, and make Your face to shine upon us, as You give us Your peace. We pray in Your merciful Name. Amen.

PLEDGE OF ALLEGIANCE

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

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 30, 2009.

To the Senate:

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

ROBERT C. BYRD,
President pro tempore.

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

RECOGNITION OF THE MAJORITY LEADER

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

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

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

The legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

SCHEDULE

Mr. REID. Mr. President, following leader remarks, there will be a period of morning business until 3 o'clock today. At that time, the managers of the bill will be here. Until that time, Senators will be allowed to speak for up to 10 minutes each as in morning business.

At 3 p.m., the Senate will resume consideration of the health care legislation. Today, the majority will offer the first amendment and the Republicans will offer the next amendment to the substitute. No other amendments, by virtue of the order that was entered before the Thanksgiving recess, will be in order today.

There will be no rollcall votes during today's session, and the next vote will occur at noon tomorrow on the confirmation of the nomination of Jacqueline Nguyen to be a U.S. District Judge for the Central District of California.

HEALTH CARE REFORM

Mr. REID. Mr. President, the next few weeks will tell us a lot about whether Senators are more committed to solving problems or creating them. We have before us a historic occasion. That is where we are—a time in history where we have never been before—with the chance to ensure the well-being of both our fellow citizens and our recovering economy. We have before us the opportunity to relieve the suffering of many and prevent even worse pain in the future.

But if we are to seize this opportunity, this debate must be on facts, not fear. We must remain focused on how we can best help the American people and the American economy, and we must avoid the temptation to drown in distractions and distortions. In other words, we must do our jobs.

Last week, my counterpart—the distinguished Republican leader, Senator

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

MCCONNELL—called the health care crisis manufactured. The American people would beg to differ. I have said on this floor before, on several occasions, that last year 750,000 people filed for bankruptcy. That is true. I said previously that half the people who filed bankruptcy filed because of medical expenses. But we have learned of a report that came out last week which states that number is too small; that, realistically, it is about 70 percent of the people who file for bankruptcy file because of health care costs.

I have also said on this floor that half the people who filed for bankruptcy because of medical expenses did so even though they had insurance. We learned last week that number is also too small; that it is 62 percent. That means 62 percent of the people who filed for bankruptcy because of medical expenses were already insured. Is that a crisis in America—750,000 people filing for bankruptcy and about 70 percent of them filing because of health care costs, with 62 percent of those who filed for bankruptcy because of health care costs having health insurance? What a sad commentary on the present state of the health care delivery system in our country.

This weekend the assistant Republican leader said we should go back to square one. In fact, his exact quote was: ''There is no way to fix this bill.'' That is what we do. We are legislators. I have been in Congress a long time. I have been fortunate to get things passed and never, ever have I gotten the legislation I wrote passed the way it was written. With rare exception that happens.

I would say to my friend, the junior Senator from Arizona, that Republicans have had a seat at the table from the very beginning of the health care debate. An example of that was in the HELP Committee, where 161 of the amendments Republicans offered in that committee were made a part of the bill that was reported out of that committee. So when you hear someone say there is no way to fix this bill, you have to look at the underlying statements this gentleman has made in the past: Basically, there is no problem with health care; things the way they are, are just fine; the fact that 750,000 people filed for bankruptcy last year, 70 percent because of health care costs, not important.

That is exactly what the legislative process is all about—changing things, working on things, trying to improve them, taking out things you don't like, debating, amending, and improving. Democrats stand ready to do so. I hope my Republican colleagues recognize that, even if the party leaders deny it.

As we round the latest turn along this journey, I renew my plea to this body—to Senators, Democrats, and Republicans: Let us discuss the specifics of this bill, not the whispers and wild rumors. While we disagree at times, let us at least agree that doing nothing is not an option. While each of us may not say yes to each word of this bill as it currently reads, let us at least agree that simply saying no isn't enough.

We will do this work transparently, and we will do this work tirelessly. That may mean debating and voting late at night. It definitely means, I say to everyone within the sound of my voice, the next weekends—plural—we will be working. I have events this weekend that I will have to postpone; some will have to cancel. That is the way it will have to be with everyone. There is not an issue more important than finishing this legislation.

I know people have things they want to do back in their States and rightfully so. I know people have fundraisers because they are running for reelection. I know there are other important things they have to do. But nothing could be more important than this. We notified everybody prior to the break we would be working weekends. Our cloakroom did so by e-mails. We have transmitted this message time and time again. So we are going to have to work Saturdays and Sundays.

This crisis—and, yes, it is a real crisis—is simply too hazardous to our country and to its health not to work as much and as long as we have to. This is a good bill we have before us. It saves lives, saves money, and saves Medicare.

The evidence about this continues to pour in. Just a few days ago an MIT economist—one of the Nation's foremost economists—a man by the name of Jonathan Gruber, analyzed our bill and concluded it will help Americans pay less and get more. He found that while the cost of private insurance continues to rise at extremely rapid rates, those who use the new health care insurance changes we propose will save hundreds, and in some cases thousands, of dollars per year per person.

I am gratified we have already taken health insurance reform further than at any point in American history, but I am not satisfied and will not rest until we finish the job. Health care fairness will come if we dedicate the coming weeks to solutions, not scare tactics.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, I wish to reiterate the point the majority leader made—that he is anticipating us being in on the weekends—and to underscore why that seems to be necessary, which is because the majority is intent on passing this health care bill that the American people oppose. We know that from all of the surveys.

In addition to that, there are a number of things that actually must be done this month: We have a debt ceiling expiring, or needing to be expanded, according to the administration; we have not passed appropriations bills; there are tax extenders that expire at the end of the year; there are PATRIOT Act provisions that expire at the end of the year. There are many things we must do this month. Yet we are going to spend an enormous amount of time working on a bill the American people wish we would not pass this month.

Let me, first, welcome everybody back—Senators and staff—after what, hopefully, was a restful and happy Thanksgiving. I actually worked Monday and Tuesday of last week, and I had a chance to spend a good deal of time out in my State of Kentucky with a number of folks. I must tell you nobody was shy about telling me what they thought about the health care bill. Nobody was shy about it. They had obviously been paying a lot of attention to it. Many had focused on the vote to proceed to this 2,074-page bill, Saturday a week ago. Many people have an opinion. So far, not a single, solitary Kentuckian did I run into—admittedly, this is anecdotal—but not a single, solitary one said anything other than you have to stop that health care bill. I assured them we were going to do the very best we could to either dramatically change it by amendment or, hopefully, on a bipartisan basis, keep this 2,074-page bill from passing.

A lot of people I met had that kind of observation. I expect it is pretty similar across the country. Kentuckians want to know how spending trillions of dollars we don't have on a plan that raises health insurance premiums and taxes on families and small businesses is good for health care or for jobs or for the economy, for that matter. The fact is, Americans feel like they have been taken for a ride in this debate, and they are beginning to realize what administration officials meant when they said a crisis was a terrible thing to waste. Early this year, they said: A crisis is a terrible thing to waste.

The notion that we would even consider spending trillions of dollars we don't have in a way the majority of Americans don't even want is proof this health care bill is completely and totally out of touch with the American people. It is now perfectly clear what happened. The administration and its allies in Congress have wanted to push government-run health care for many years, and they view the economic crisis we are in as their moment to do it. So they sold their plan as an antidote to the recession, even though their plan would only make things worse. But now Americans are beginning to see the truth behind the rhetoric. No one believes—no one—that trillions in spending, taxes, and debt will do anything but kill jobs and darken the economic prospects of struggling Americans and their children.

The administration's health care plan will not alleviate the situation we are in. Instead, it would punish struggling Americans at a moment when all they want is a little help.

Proponents of this bill couch their efforts with the refrain that history is calling. I think they have got it half right. Someone's calling all right, but it is not history. It is the American worker. He is wondering where the jobs are. It is the middle-class family wondering how Congress could try to pass a scheme that won't do anything to control costs. It is one of the roughly 40 million seniors wondering when Medicare became a piggy bank to fund more government and higher premiums.

I have enumerated the specifics about the Medicare cuts in this bill before: nearly $135 billion in cuts to hospitals, $120 billion in cuts to Medicare Advantage, nearly $15 billion in cuts to nursing homes, more than $40 billion from home health agencies, early $8 billion from hospices—hospices. Nearly one-half trillion dollars in cuts: this is what some have audaciously started referring to as ''Saving Medicare.'' I don't know what's more preposterous: saying that this plan ''saves Medicare,'' or thinking that people will actually believe you.

Arthur Diersing gets it. He is a constituent of mine from Versailles, KY. Here's what he had to say about this plan. He wrote:

> I . . . agree that there are some things in the health care system that need to be fixed or improved. But let's work on the most important 5–6 issues rather than turn the whole system upside down, and run up the cost for all of us and take away from us seniors.

Mr. Diersing knows what he is talking about. He knows this bill doesn't reflect the views of the American people. Americans have been asking us to cut costs, not raise them. They want the kinds of step-by-step reforms that would actually make a difference, without bankrupting the country and without further expanding the role of the government in their lives. Americans don't want this bill to pass. Instead, they want us to earn their trust with the kind of commonsense reforms Republicans have been talking about all year and which our friends have brushed aside.

Americans want us to end junk lawsuits against doctors and hospitals that drive up costs. And yet there is not a serious word about doing so in the 2,074 pages of the Democrat bill. Americans want us to encourage healthy choices like prevention and wellness programs. And yet Democrat leaders couldn't come up with a serious word about these kinds of reforms in 2,074 pages.

Americans want us to lower costs by letting consumers buy coverage across State lines. They want us to let small businesses band together to negotiate lower insurance rates. And yet Democrats have ignored both of these ideas, despite having 2,074 pages to include such ideas.

Americans also want us to address the rampant waste, fraud, and abuse in the current system before we create an entirely new government program. And yet Democrats don't seriously confront this problem in their 2,074 page monument to more government, more taxes, more spending, and more debt.

Americans are fed up with big-government solutions that drive up taxes and debt and which only seem to create more problems, more abuse, and more fraud.

In the face of this, our friends on the other side of the aisle appear determined to plow ahead with their plans. They don't seem to care that Americans are telling them to stop and start over and fix the problem, which is health care costs.

Democrat leaders may think they hear history calling. But the sounds they should be hearing are the voices and the concerns of ordinary Americans. The American people will be heard in this debate, I assure you. In a democracy, public opinion should not be and never is irrelevant.

At the beginning of the health care debate, we were told this $1 trillion experiment would actually lower premiums for American families. Yet just this morning, this very morning, the independent Congressional Budget Office provided an analysis showing that the Democratic bill will actually increase premiums for American families. That is the CBO this morning. It indicated this will actually increase premiums for American families. So a bill that is being sold as a way to reduce costs actually drives them up.

The bottom line is this: After 2,074 pages and trillions more in government spending, massive new taxes and one-half trillion dollar cuts in Medicare, most people, according to the Congressional Budget Office—most people—will see their insurance premiums go up. This is not what the American people are asking for, and it certainly is not reform.

I yield the floor.

RESERVATION OF LEADER TIME

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

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. There will now be a period for morning business until 3 p.m. with Senators permitted to speak for 10 minutes each.

The Senator from Florida is recognized.

HEALTH CARE REFORM

Mr. NELSON of Florida. Mr. President, when we start the debate on the health bill, I will be exceptionally eager to take the floor and to address some of the points the Republican leader has just addressed.

Most of us went home. As the minority leader said, most of us heard from our constituents who were not bashful about expressing their opinions. It is interesting that a lot of those opinions I heard were from the people who are just reeling in agony because they are in the middle of some medical procedure such as chemotherapy and suddenly they get a notice from their insurance company that they are canceled or they are desperate to get health insurance coverage and have been terminated from their job where they had it, and then an insurance company tells them they will will not insure them because they have a preexisting condition.

I do not believe there is anybody in America who is satisfied with the way the overall health care and health insurance industry delivery system is giving us our health care. Whenever it is said this bill that is before the Senate now is going to increase the cost, let's remember our costs are already increased by the people who do not have insurance who end up at the most expensive place, which is the emergency room, since they have not had any preventive care when they are in an emergency. All of the rest of us pay for it. On average that is $900 to $1,000 that is tacked on to our insurance policies we are paying as a hidden tax to pay for all those whom, if brought into the health insurance system, we would not be paying for.

I will save the rest of my remarks until we get on the health bill.

THE ECONOMY

Mr. NELSON of Florida. Mr. President, I want to take this time to talk about this terrible economic recession. To those people, by the way, who do not have a job, it is not a recession, it is a depression. The times are difficult economically all over this country but especially in my State of Florida which has an unemployment rate that is well above the national average, and there are pockets in Florida where the unemployment rate is exceptionally soaring, such as southwest Florida. It is this continued economic devastation from home foreclosures, business closings, and high unemployment rates that is threatening the prosperity of the country and particularly States such as mine, Florida.

For example, in southwest Florida, we learned last week that another local bank had been shut down by Federal regulators. It is the sixth bank failure to hit that region this year. On the housing front, numbers were released that indicate Fort Myers still has a long way to go to climb out of the housing mess. While the positive news was that foreclosures had declined 20 percent from September to October, the area still ranks fifth in the country in foreclosures.

We need to continue the steps to get the housing market back on its feet. One of those steps we did included the $8,000 tax credit for first-time home buyers. That goes through next spring. Most recently, we took one step further when we passed a $6,500 tax credit for existing homeowners who sell their

home and want to buy another. That has spurred home sales.

We need to stabilize the prices, which remains the top priority. We also need to keep the pressure on the banks, the lenders, to work with folks who are losing their homes.

Many places across the Nation, and specifically Florida, are responding to the crisis by adopting mandatory mediation as an alternative to foreclosures, thereby forcing banks to modify mortgages and avoid a foreclosure altogether.

A great success story is a program in Philadelphia where borrowers can keep their homes in a program that is being looked upon as a model for the rest of the Nation. Under a plan put in place by the city's civil court, no property can be foreclosed in that court and sold by the sheriff until the mortgage company sits down with the homeowner to try to find a solution.

Unlike the administration's effort to stem foreclosures, which relies on giving incentives to mortgage companies to encourage them to work with homeowners—a program that has not worked as the Obama administration has intended—the Philadelphia program, in contrast, is not a voluntary program. Mortgage companies are forced to participate. While that Philadelphia program will not result in every troubled homeowner getting the outcome they are looking for, making those lenders come to the table is a step in the right direction. But if we are going to bring back health to our banking and financial system, we are going to have to fix the problems that are driving our community and regional banks to insolvency. The crisis in residential and commercial real estate values, home foreclosures, and nonperforming commercial real estate loans is wiping out those regional and local bank balance sheets.

In response, those regional banks are desperately hanging on to their deposits and other assets. I wish I didn't have to say this, but the Obama administration, particularly Secretary Geithner, has not done a good job in leading our banking system and real estate markets to recover. Their response to the collapse in residential real estate was a tepid loan modification program which in most cases kicked the can down the road for the few underwater homeowners who were fortunate enough to qualify. Their response to the crisis in commercial real estate has been absent altogether. The consequence is that the commercial real estate market is on the verge of its own collapse as creditors are reluctant to refinance commercial projects.

Half way through the year, Florida banks had over $5 billion of commercial real estate loans in default. Commercial real estate makes up over one-third of the assets of Florida banks. These growing liabilities are putting the brakes on bank lending in Florida, and they are hurting creditworthy small businesses and prospective home buyers. It is a vicious downward spiral that is not easily broken. One thing is clear: The Troubled Asset Relief Program has not been the answer.

When then-Secretary of the Treasury Hank Paulson, the former head of Goldman Sachs, first proposed TARP, there were a number of us on this floor who opposed and voted against it. I thought it was massive and a wasteful bailout of the Wall Street banks with zero accountability and no meaningful reform. What have we found out about it? Of the $700 billion that Congress appropriated for TARP, over $220 billion has yet to be loaned out and only some $70 billion has been repaid. I believe we should end the program once and for all and return those funds to the U.S. Treasury to prevent us from falling deeper into fiscal debt and a fiscal black hole. Bringing the deficit under control would then help stabilize interest rates. It would hold borrowing costs down, and it would reduce the growing debt burden on future generations. That still leaves roughly $400 billion of TARP funds outstanding.

Bank of America, Citigroup, and Wells Fargo need to repay the TARP funds that have propped them up for more than a year. They need to stand on their own feet. Banks such as Goldman Sachs that have repaid their TARP funds still owe a tremendous debt to American taxpayers. Goldman Sachs, Merrill Lynch, and a slew of other banks all profited from the dollar-for-dollar taxpayer bailout of AIG's credit default swaps, those insurance policies. Under that AIG bailout, the most outrageous of all the bailouts, $70 billion of American taxpayer funds was put at risk to ensure that speculators in credit default swaps were fully protected. The head of Goldman Sachs recently apologized for his firm's reckless behavior and pledged to commit $500 million for small business lending. That sounds like a serious commitment, until we consider that Goldman Sachs has set aside $17 billion for year-end bonuses. So while Main Street is tightening its belt and preparing for a lean holiday season, Wall Street is still living high on the hog. That must change.

As banks repay their TARP loans, we need to consider how we use those funds, how we reform the financial sector. To get us back on track, we will have to be creative and find new solutions to ensure that businesses have access to the capital they need to grow, prosper, and hire new workers.

I have a few suggestions. First, we need to scrap the trickle-down TARP model and start working from the bottom up. We need to focus on access to capital for small businesses and ways to shore up residential and commercial real estate values. TARP has focused far too much on the largest Wall Street banks at the expense of community and regional banks, the backbone of finance in Florida. We need to increase Federal support and assistance to community banks and credit unions.

Second, we need to look at other ways to improve access to capital such as promoting direct lending by the Small Business Administration.

Third, we need a flexible approach to dealing with underwater homeowners, those whose value is now less than the value of their mortgage, which is so typical in the State of Florida. A flexible approach would be like the one in Philadelphia which is undertaking to require mediation and loan modifications.

These are a few suggestions I have in this very tough economic time.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

Mr. KYL. I ask unanimous consent to speak up to 20 minutes in morning business.

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

HEALTH CARE REFORM

Mr. KYL. Mr. President, I rise to talk about the health care legislation because in a few minutes the official debate in the Senate will commence. The American people will have before them the full panoply of arguments both for and against the legislation. They will make their judgment about whether we are in fact carrying out their will.

According to public opinion surveys, the will of the American people is that this bill should not pass. According to a relatively new Rasmussen poll, by an 18-point margin, Americans say this bill should not pass. By 56 to 38, they oppose it. In terms of people in the middle, the independents or other voters not identified with either political party, the percentage of people who oppose the legislation is even greater. More than 3 to 1, Independents oppose this legislation. The majority believes it will both increase their costs and decrease the quality of health care. It is for these reasons that I indicated before—and I will say it again—I don't think this bill can be fixed. In fact, I don't think the majority will allow it to be fixed. That is why, along with my Republican colleagues, I believe we should start over and attack the problems that face our country in a more realistic way, in a step-by-step approach, first to win back the confidence of the people and then to provide elements of relief to each of the problems we face, rather than trying to tackle the entire health care system, the government programs, the private programs, the insurance, the physicians, the hospitals, trying to do it all in one giant bill that results in massive government takeover, over $1 trillion—in fact, $2.5 trillion—in expenditures, massive new debt, more taxes, higher insurance premiums, all of which will result in, ultimately, the rationing of health care which is, to me, the most dangerous part of this entire exercise.

Somehow or other, we could probably pay the expense of this. Somehow or

other we will survive. But we won't survive the life-and-death decisions that are made every day by patients, doctors, and families, if the government begins intruding between the patient and the physician, begins making decisions about what kind of health care we can have, what kind of health care the government will allow payment for and the like. Those become life-and-death decisions. That is why Americans feel so strongly and personally about this debate and about the decisions we are about to be making here.

Let me address something the distinguished majority leader said a moment ago, and then I wish to talk a bit about Medicare as one of the aspects of this insurance debate.

The majority leader said that Republicans have had a seat at the table. I am on one of the two major committees, the Finance Committee. I think one amendment was adopted. It was an amendment offered by a Republican and a Democrat on the committee. There were well over 100 amendments that Republicans offered that were all shot down, defeated, largely on party-line votes. I say to my distinguished friend from Nevada that maybe we have a seat at the table but it is a little like the kids table at Thanksgiving dinner where you are told to mind your manners and keep the noise down. That is the way Republicans feel about our role at the table in fashioning this legislation.

The majority leader himself would acknowledge that after the two committees in the Senate acted, he went behind the closed doors of his office and, along with representatives from the White House and a couple of other Democratic Senators, no Republicans at all, legislation was developed in his office that he then presented here on the Senate floor just before the Thanksgiving recess. That is how the legislation got developed. It was without Republican participation.

We will have a chance to amend this bill. Maybe he will prove me wrong. Maybe he will demonstrate that we can fix this bill.

I do, with all deference, disagree with his comment that the motivation of Republicans is to do nothing. Of course, he frequently says doing nothing is not an option. Nobody is arguing about doing nothing. Republicans have presented some very good ideas to do something, to do a lot of somethings. Our ideas have been rejected. Let's don't get into false debate about doing something or nothing and the only alternative is the bill that is on the Senate floor. There are alternatives, and I will discuss one group of alternatives we have presented in a moment.

There will be a good test to see whether in fact we can amend this bill or if my prediction that there is no way to fix it will turn out to be true. That has to do, first and foremost, with what this bill does to Medicare, the program we have developed for seniors. Let me go over some of the Medicare cuts in this bill and then ask my Democratic colleagues if they are willing to join Republicans in restoring these provisions of Medicare—in other words, in striking these cuts—if they are willing to join Republicans in that effort. Then maybe the majority leader is right. Maybe we can fix this bill. If they are not willing to do that, then I resubmit that this bill can't be fixed, and it can't because our Democratic friends won't allow it to be fixed.

Here are the ways this bill cuts Medicare benefits for seniors: $137.5 billion is cut from hospitals that treat seniors; $120 billion is cut from Medicare Advantage. I will return to Medicare Advantage in a moment. That is the private insurance company that somewhere around a quarter to a third of seniors take advantage of. Well over a third of the seniors in Arizona, approaching 40 percent of Arizona seniors, participate in the Medicare Program, the benefits of which are substantially cut. Continuing, $14.6 billion is cut from nursing homes; $42.1 billion from home health care, $7.7 billion from hospice care. That is a total of $464.6 billion in Medicare cuts. Seniors know we can't make these kind of cuts without jeopardizing the care they receive. That is the concern I have. We are not talking about cuts in the abstract. We are talking about delay and denial of care for American citizens. These folks wonder how it is fair or justifiable to cut the health care that has been promised to them in order to pay for some kind of new government entitlement.

I receive letters and phone calls every day. I have quoted from many of these letters. Many of them have to do with the proposed cuts in Medicare, in particular to Medicare Advantage.

I mentioned the percentage. In numbers, it is about 329,000 Arizonans—329,000 Arizonans—a third of a million who enjoy Medicare Advantage plans. That is over 37 percent of overall Medicare beneficiaries in my State of Arizona. They know $120 billion in Medicare Advantage cuts will hit our State and, specifically, their coverage very hard. They worry that under the Reid bill, they will lose the low deductibles and the low copayments they enjoy under Medicare Advantage and many of the other benefits I mentioned a moment ago.

They worry about losing the choices they have, which is one of the nice things about the Medicare Advantage plan, and the extra benefits, including things such as eyeglasses, hearing aids, dental benefits, preventative screening, free flu shots, home care for chronic illnesses, prescription drug management tools, wellness programs, medical equipment, and access to physical fitness programs. These and many more are the kinds of benefits that are included in the Medicare Advantage Program, and they will lose many of these benefits under the legislation that is before us right now.

I think they have a right to be concerned about losing these benefits. If there is any doubt about this, incidentally, the Congressional Budget Office, which is a nonpartisan entity which serves both Democrats and Republicans here—it calls it straight; sometimes they give answers we do not like, but they provide the analysis of the costs and benefits—and the Congressional Budget Office has confirmed that under the Democrats' bill, Medicare Advantage beneficiaries will lose, and they will lose big. In fact, they will lose more than half their extra benefits under Medicare Advantage.

Well, my senior citizen constituents do not like that, and they have let me know about that. Let me share a couple letters—just excerpts from letters from two of my constituents. The first is from Surprise, AZ:

> My mother is on Medicare Advantage, and I don't know what she would do without it. The poor and middle class are already hurting much more than government officials realize. We are on fixed incomes, and have already cut back to bare minimum. What happened to ''government for the people, by the people?''

Another constituent from Gold Canyon, AZ, writes:

> I have been on Medicare for 11 years and have been subscribing to a Medicare Advantage plan for the past 6 years. It has been excellent, and has provided substantial savings for us. Now we understand that the government is dropping its support of the plan. Please try to stop this. It is very important to many senior citizens in Arizona.

These constituents of mine, these senior citizens, know Medicare cuts will hurt seniors' care, and those who try to suggest otherwise are simply wrong. The Congressional Budget Office, as I have said, has confirmed it.

One of the newspapers on Capitol Hill, Politico, recently provided a helpful summary of an actuarial report on the Democrats' health care plan, prepared by the Centers for Medicare and Medicaid Services. That is CMS. That is the outfit out of the Department of Health and Human Services that actually runs Medicare. According to page 8 of the report, as Politico summarizes, the Democrats' bill:

> . . . reduces Medicare payments to hospitals and nursing homes over time, based on productivity targets. The idea is that by paying institutions less money, they will be forced to become more productive. But it's doubtful that many institutions can hit those targets, which could force them to withdraw from Medicare.

We hear it all the time: physicians dropping or not taking any new Medicare patients; entities that are no longer going to be able to serve Medicare patients because they are not getting paid enough by the government for them to even break even.

This report I am quoting from—the CMS report—according to Politico, says that by 2014, Medicare Advantage enrollment will plunge 64 percent—we are not talking about just a few folks—from 13.2 million down to 4.7 million because of the ''less generous benefit packages.''

One of the reasons this is being done is because those on the left do not like private competition for the government program, Medicare. What I think they fail to appreciate is what my constituents have appreciated, which is this private alternative to regular Medicare provides additional benefits, additional health protections. If they are willing to pay a little bit more for those benefits, why shouldn't they be allowed to take advantage of those benefits? No. Those on the left say: We don't want any private insurance companies competing to get Medicare patients. We want that to be strictly a government program.

Well, if folks like it, why shouldn't they be allowed to keep it? Remember what the President said: If you like your insurance company, you get to keep it. No, that is not true, according to this. Medicare Advantage enrollment will plunge from 13.2 million to 4.7 million because of the ''less generous benefit packages.'' So I guess it is not true: If you like it, you get to keep it.

The Washington Post—a newspaper here in Washington—wrote an article about the Center for Medicare and Medicaid Services report, the same one I have been quoting here, and the headline was ''Bill Would Reduce Senior Care.'' Well, that says it in a nutshell. The story goes on to tell us: ''A plan to slash . . . Medicare spending—one of the biggest sources of funding for President Obama's proposed overhaul of the nation's healthcare system—would sharply reduce benefits for some senior citizens.''

''Would sharply reduce benefits.'' So the Medicare cuts, as proposed by the majority, do, in fact, jeopardize seniors' benefits. The majority leader says we can amend the bill, and that is hypothetically correct, of course.

Let's see how many of our Democratic colleagues are willing to join Republicans in striking these Medicare cuts, the cuts I have just now been referring to. If we do not do that, then I will repeat what I have said before, which is that we should start over because it is clear this bill is not going to be fixed and starting over would mean taking some of the Republican suggestions.

Let me talk about one of these suggestions. My colleague from Florida was talking about the sorry state of real estate in his State of Florida, and I could have added my State of Arizona as well. I agree with much of what he had to say about that. But he also noted, with regard to health care, there is a subsidy in what those of us with private insurance pay because of the care that is given to others who cannot always pay for all of it. That is true.

I would add, there is also a subsidy for what we pay in insurance premiums because of the government programs, such as Medicare and Medicaid, which, likewise, do not pay for all the benefits they provide. In fact, they only pay doctors and hospitals somewhere in the neighborhood of 70 to 80 percent of their cost, and we have to make up the difference in that in the private insurance premiums we pay. So increasing insurance premiums is, to a large degree, the fault of the U.S. Government, not the insurance companies.

The Democrats say the answer is yet another government program, and they even have a government insurance program in the legislation they have introduced. Their other answer is to write insurance policies. They actually specify in the bill what policies have to include. These are called government mandates. What is the effect of these proposals? Is this the right way to go or is there a better idea?

Again, the Congressional Budget Office, which the distinguished minority leader referred to a moment ago, in its most recent report said—and it said the same thing to the Finance Committee—the premiums for private insurance under this Democratic legislation will, what, go up. The average family is going to pay more in insurance premiums under this legislation, not less.

What was the whole idea here? The whole idea of health care reform was to reduce the cost of health care, to reduce our insurance premiums. They are skyrocketing. My colleagues on the other side of the aisle say: Small businesses cannot afford to buy insurance for their employees; my constituents cannot afford their health insurance premiums, which are increasing in price. All that is true. They are increasing. So what should we be doing? We should be lowering them, not raising them. This legislation, according to the Congressional Budget Office, increases insurance premiums.

What about the Republican alternative, the alternative that was presented in the House of Representatives by the House Republicans? That alternative, according to the Congressional Budget Office, reduces average insurance premiums by $5,000 a year. So on the one hand, you have the Democratic proposal, which increases insurance premiums; on the other hand, you have the Republican proposal, which decreases premiums.

There is a study by a private consulting firm, Oliver Wyman, which breaks this down by State. The reason I am excited about this Republican idea is the average family in Arizona would see its premiums go down annually by over $7,400. So think about that. On the one hand, you have insurance premiums going up, under the Democratic legislation; under the other, you have insurance premiums going down, on average, somewhere in the neighborhood of anywhere from $3,300 to, in my State, up to $7,400. I think the average is somewhere between $3,000 and $5,000.

The point is, you can cut insurance premiums with better ideas coming from Republicans, and I just ask my colleagues: Why wouldn't you do that as opposed to the complicated, costly, government-run kind of program you are trying to institute under this legislation, which, according to CBO, would raise insurance premiums?

That is why the American people, by a significant margin, say: Do not pass this bill, why they appreciate it would raise their costs, it would reduce the quality of their health care, and why, therefore, my colleagues and I are going to try our best to persuade our Democratic colleagues to amend the bill. But if at the end of the day they are not willing to buy some of these good Republican ideas and instead insist on pushing right ahead with their legislation, at the end of the day, we will have to say: We are sorry, it does not appear this bill is going to be fixed and, therefore, we are going to follow the wishes of the American people and see to it that it does not pass.

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

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

ORDER OF PROCEDURE

Mr. REID. Mr. President, the Senator from Minnesota is here. She has a brief statement to make. I ask unanimous consent that she be allowed to speak for 5 minutes and then we go to the bill.

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

The Senator from Minnesota.

DETENTION IN IRAN

Ms. KLOBUCHAR. Mr. President, I come to the floor to call attention to the situation of three citizens of the United States—Shane Bauer, Sarah Shourd, and Josh Fattal—who have been detained by the Government of Iran for nearly 4 months. One of these individuals, Shane Bauer, comes from my home State of Minnesota, and so the safe return of these three young Americans is of particular importance to me.

On July 31 of this year, Shane, Sarah, and Josh—who shared a common passion for travel and discovery—were on a hiking trip in a peaceful region in northern Iraq, when they reportedly accidentally strayed across the poorly marked border between Iraq and Iran and were surrounded by Iranian border guards.

Since then, Shane, Sarah, and Josh have been held in near isolation in a Tehran prison and have been allowed no contact with their families in the United States.

Despite repeated requests by the Swiss Government, which represents U.S. interests in Iran, the three have

been denied regular consular access required by the Vienna Convention. They have been denied repeated requests to be able to speak with their families via telephone, and they have been denied public information on any charges they may face.

In the 4 months they have been detained, the three have been allowed only two meetings with Swiss consular officials and have been denied due process and access to legal representation.

Even more alarming, Iranian officials have recently declared the three may be charged with espionage, a charge that is not only baseless but also completely at odds with who Shane, Sarah, and Josh are as individuals.

Shane, Sarah, and Josh made a simple mistake in accidentally crossing the border, and their continued detention is unwarranted and unreasonable. Since the three were detained, I have gotten to know Shane's mother Cindy and other members of the hikers' families. During our conversations, I have learned what a remarkable person Shane is and how he is dedicated through his work to bringing the world closer together through photo journalism.

Shane grew up in Onamia, MN, a small town in the central part of our State, and he graduated from the University of California at Berkeley. Prior to being detained in Iran, Shane was living with Sarah in Damascus. He has traveled around the Middle East as a free-lance journalist, reporting from Syria, Iraq, Darfur, Yemen, and Ethiopia. His writing and award-winning photographs have been published in the United States, the United Kingdom, Canada, and throughout the Middle East.

His latest trip with Sarah and Josh brought him to the Kurdistan region of Iraq, which is known for its scenic hikes among mountainous waterfalls. This is hardly the background of someone who would deliberately enter Iran in hopes of committing espionage.

A few weeks ago, I met with Shane's mom Cindy and members of Sarah and Josh's families in my office in Washington. As a mother, I can only imagine how difficult this ordeal must be for all of them. They have had no contact with their sons or their daughter. Yet I have been overwhelmed by their resolve. They are pursuing every avenue they can find to demonstrate to the Iranian Government that their children made a simple mistake and clearly deserve to be released.

I came away from our meeting even more committed to seeing that Cindy and Shane, along with Sarah and Josh and their families, are united as soon as possible. As we all know, Iran is in the center of many pressing foreign policy challenges we currently face. I, along with my colleagues, will address those, but Shane, Sarah, and Josh have absolutely nothing to do with these international fights. They have nothing to do with what is going on in Iran or Iran's differences with other countries. This is strictly a humanitarian case. I urge Iranian officials not to politicize it or seek to use the three hikers as diplomatic pawns. There is no cause for their continued detention, and nothing will be gained by prolonging it any further. Iran's leaders should demonstrate the necessary compassion by immediately releasing Shane, Sarah, and Josh and allowing them to return home to their families. In the meantime, they should at the very least allow them to speak to their families in the United States over the telephone.

I thank my friend, the Ambassador to Switzerland, and Swiss officials for their work in this area. It has been 122 days since Shane, Sarah, and Josh were first detained; 122 days in captivity, apparently just for straying over a line on a map when they were on a hike. We will continue to work with the families, with the State Department, and Swiss officials to do everything we can to bring Shane home to Minnesota.

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

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

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.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. REID. Mr. President, today is the beginning of one of the most important debates in the history of our country. Today is the beginning of one of the most historic times in the Senate. Our two chairmen, Senators BAUCUS and DODD, have spent months of their lives working on the legislation that allows us to be where we are today. We now have before us a bill that saves money, saves lives, and saves Medicare. It is a bill, if you add in Medicare recipients, that will insure 98 percent of the people in America.

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

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

Mr. REID. Mr. President, one of the major goals of the Patient Protection and Affordable Care Act is to lower Federal health care costs and reduce the deficit. Our bill does that. According to the nonpartisan Congressional Budget Office, this legislation would not add a penny to the Federal deficit. In fact, it will reduce the deficit over both the short term and the long term, over the long term by as much as $650 billion.

In developing this bill with the Finance and HELP Committees, we were determined to ensure that the legislation not only would reduce our deficit and our debt but that it would do so without relying on additional surpluses in the Social Security trust fund. This legislation would increase revenues in the trust fund as workers' wages rise. But those revenues are supposed to be for Social Security, so we didn't touch a penny of them—they are all used for Social Security and nothing else.

Likewise, about $70 billion in revenues over the first 10 years of this bill flows from premiums paid into the new long-term care insurance program known as the CLASS Act. Several Members came to me and argued that none of these funds should be used for other purposes. I agreed. After all, these premiums would be used to build up a fund that later would be used to pay benefits. So, as with Social Security, we didn't use any of the CLASS surpluses for other programs.

I think it is important that as the Senate considers changing the legislation, we maintain our commitment to protecting Social Security and CLASS surpluses. In both cases, all additional revenues are dedicated to pay benefits. Diverting them to other purposes would not be fiscally responsible, and it wouldn't be fair to Social Security or to people who paid their CLASS premiums in good faith.

To help ensure we remain true to this commitment, I now ask unanimous consent that all amendments to the pending bill be considered out of order unless they are consistent with the following two principles: The additional surplus in the Social Security trust fund generated by this act should be reserved for Social Security and not spent in this act in any other fashion; and No. 2, the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in any other manner in this act.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Reserving the right to object, neither of these requests are the requests I was just talked to about a minute and a half ago, so I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, I think what he saw a minute and a half ago is essentially the same thing, but I will recite this again.

I ask unanimous consent that no amendment be in order to the Reid substitute amendment 2786 or a subsequent substitute amendment and H.R.

3590 if the additional surplus in the Social Security trust fund generated by this act would be expended on other provisions of this act and not reserved solely for Social Security, and the net savings generated by the CLASS program in the underlying substitute amendment and any subsequent substitute amendment are reserved solely for the CLASS program provisions of this act.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Mr. President, in the weeks this has been sequestered without us being able to review it and now having something that is not understandable in the short period of time we have to do it here, I have to object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, I am sorry my friend objected. It is not too difficult to comprehend that any Social Security surpluses should be reserved for Social Security. It is not too difficult to comprehend that all monies related to the CLASS Act would be reserved for paying benefits for that. So I am disappointed that my friends on the other side of the aisle are not interested in making sure Social Security monies are not used and/or CLASS Act monies are not used for anything other than those two programs.

Mr. President, I have another unanimous consent request.

The process for developing this legislation has been very transparent. In fact, the hearings held in the Finance Committee were done very publicly, and that is an understatement. For weeks and weeks, members of that committee couldn't walk out of the room without being questioned by the press. The press was present at most of their meetings. So both the HELP and Finance Committees marked up their legislation in public markups. Republican and Democratic members of both committees offered numerous amendments, all of which were available to the public. Republican and Democratic members voted for or against those amendments in a public and transparent way, and each committee member can be held fully accountable to their constituents for all of those votes.

The merged bill before us is entirely consistent with the provisions produced in those public markups. The bill has been fully available on the Internet for about 2 weeks. So each and every American has had the opportunity, if they wanted, to read the text of the legislation and to communicate their views with their Senators.

One of the main reasons we have gone the extra mile in ensuring a fully transparent process is because of the leadership of Senator BLANCHE LINCOLN of Arkansas. From the very start of this debate, she has made clear to me that a transparent process and debate on this critical issue is a top priority of hers. To that end, Senator LINCOLN said she would not allow a vote on the motion to proceed to this bill unless it had been available to the public for a reasonable period of time. She was joined by virtually everyone on this side of the aisle to that effect. They were right. The people did deserve a chance to see the bill before that vote, so we were sure to give them that chance. The Senator deserves credit for that, and I appreciate her standing up on that issue.

She believes—and I agree—that we can do more on the transparency front as this bill moves forward to the next stage of this process; therefore, Senator LINCOLN has asked me to propound on her behalf a unanimous consent request.

I ask unanimous consent that no amendment be in order to the Reid substitute amendment No. 2786, a subsequent substitute amendment, or H.R. 3590 unless the text or Internet link to the text of the amendment is posted on the home page of the official Senate Web site of the Member of the Senate who is sponsoring the amendment prior to the amendment being called up for consideration by the Senate and the amendment is filed at the desk. Further, that this unanimous consent agreement shall be in effect for the duration of the consideration of H.R. 3590.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Mr. President, in light of some of the trust problems and transparency problems we have, and while it appears to lead to greater transparency, we can also see ways that this can limit the ability for the minority to offer amendments. Therefore, I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, this is not a good way to start this debate. No. 1, there is an objection to the moneys in Social Security being protected and, No. 2, to the moneys in the CLASS Act being protected. That was also objected to.

Finally, Senator LINCOLN's request, which I support 100 percent, indicating that amendments should be filed on a Member's Web site—that doesn't sound too outlandish—and filed at the desk before they are offered, sounds pretty fair and square to me. I am disappointed this is the way the debate started.

Mr. President, there is an order before the body that there will be two amendments in order today. One will be offered by the Democrats and one will be offered by the Republicans. The one to be offered by the Democrats will be offered by the distinguished Senator from Maryland, BARBARA MIKULSKI, who I had the good fortune of serving with in the House of Representatives. She and I came here together in 1986 when we were elected to the Senate. She is a Senator I have such great respect and fondness for. We have been literally together and, because of our seniority, I am always one step behind her. Frankly, most people are a step behind the Senator from Maryland. The amendment she is going to offer is very sound and good. She will explain it in detail. It expands women's health services. We had a consternation about mammograms a couple weeks ago, and this will put that all to rest.

I express my deep appreciation for the leadership of the Senator from Maryland on this issue and on so many other issues she is involved in.

As I have indicated, the managers of the bill on our side will be Senators BAUCUS and DODD. We look forward to a rigorous debate. With the consent of my friend from Wyoming, I ask that the Senator from Maryland be recognized.

Mr. ENZI. Mr. President, I was hoping I would have a chance to comment on the things I had to object to so I can give a more full explanation. I am happy to wait.

Mr. REID. Mr. President, there is no need to cut the Senator off. I have indicated to my staff earlier today that there is no one easier to get along with in the Senate than the Senator from Wyoming. I would never, ever cut him off intentionally. If there is anything he wishes to say, he should say it. If the Senator from Maryland will withhold for a moment, the Senator from Wyoming wishes to speak for a brief period of time.

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

Mr. ENZI. Mr. President, I cannot be brief on what just happened here. I will let the Senator go ahead. Frankly, I am a little upset about what has happened—combining a couple of unanimous consent agreements so that part of it would be acceptable and part would not be, leaving out the most important one, which is that we wouldn't take Medicare money from Medicare, and then not having much time to consider, or to rewrite, or to do anything with those. I have a lot of comments I wish to make on that, plus a general statement on the bill, which fits in with what just happened. I will defer to the Senator from Maryland.

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

AMENDMENT NO. 2791 TO AMENDMENT NO. 2786

Ms. MIKULSKI. Mr. President, I have an amendment at the desk.

The ACTING PRESIDENT pro tempore. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maryland (Ms. MIKULSKI), for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN, proposes an amendment numbered 2791 to amendment No. 2786.

Ms. MIKULSKI. Mr. President, I ask unanimous consent that 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 clarify provisions relating to first dollar coverage for preventive services for women)

On page 17, strike lines 9 through 24, and insert the following: ''ance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

''(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.''.

''Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.''.

Ms. MIKULSKI. Mr. President, before I go into the contents of my amendment, I thank the Senator from Wyoming for his unfailing courtesy to allow me to proceed to offer my amendment. I have worked with the Senator from Wyoming on the Health, Education, Labor and Pensions Committee, and have often valued his sound counsel and steady hand as we have moved complex legislation. His considerable experience as an accountant and his commitment to the stewardship of Federal funds have often added to the consideration of legislation. As we move forward on both debating and refining the health care reform bill before us, I look forward to working with him. Again, I thank him for his courtesy.

I also want to acknowledge the Democratic leader and wish to support him for bringing something called the ''merged'' bill to the floor, which took the best elements of both the Finance Committee and the HELP Committee and brought them forth.

I believe the overriding bill before us is an excellent bill. No. 1, it expands universal access to health care that will now cover over 90 percent more Americans. It will end the punitive practices of insurance companies, particularly in the area of gender, age discrimination, and preexisting conditions. It also stabilizes and makes Medicare secure and, at the same time, it begins to bend the cost curve by following innovative practices related to quality control and prevention.

I think the overriding bill is an excellent one. I congratulate the manager of the bill on the floor, the Senator from Montana, Mr. BAUCUS, chairman of the Finance Committee, for the excellent work his committee did, for bringing in a great bill that establishes new ideas, such as medical homes, emphasizing primary care and prevention, and at the same time accomplishing the objectives I have mentioned.

However, as I reviewed the bill, I felt we could do more to be able to enhance and improve women's health care. That is what my amendment does. The essential aspect of my amendment is that it guarantees women access to lifesaving preventive services and screenings.

This amendment eliminates one of the major barriers to accessing care in the area of cost and preventive services. It does it by getting rid of, or minimizing, high copays and high deductibles that are often overwhelming hurdles for women to access screening programs. We know that screening is important and early detection is important because it saves lives. But it also saves money. It does it by reducing the top diseases that are killing women today, or certainly impairing their lives.

Today, according to the CDC, the top killers of women are cancer—breast cancer, cervical cancer, colorectal cancer, ovarian cancer. Also upfront and high on the list is lung cancer which, if identified early, can be treated with less invasive procedures and with lower costs. Another top killer of women is heart and vascular disease. And then there are the silent killers that often go undetected, such as diabetes, which can result in terrible consequences, such as the loss of an eye, the loss of a limb, or the loss of a kidney.

We now have screenings that are proven to detect these diseases early. Guaranteed access to these screenings, as I said, will save money and lives.

If we look at where women are today, we find women often forgo those critical preventive screenings because they simply cannot afford it, or their insurance company won't pay for it unless it is mandated by State law. Many women right now don't have insurance at all—seventeen million women in the United States of America are uninsured—or when they are insured, they have to pay large out-of-pocket expenses.

Three in five women have significant problems paying their medical bills. Women are more likely than men to neglect care or treatment because of cost. Fourteen percent of women report they delay or go without needed health care. Women of childbearing age incur 68 percent more out-of-pocket health care costs than men, simply because of the maternity aspect.

Women are often faced with the punitive practices of insurance companies. No. 1 is gender discrimination. Women often pay more and get less. For many insurance companies, simply being a woman is a preexisting condition. Let me repeat that. For many insurance companies, simply being a woman is a preexisting condition. We pay more because of our gender, anywhere from 2 percent to over 100 percent. A 25-year-old woman is charged up to 45 percent more than a 25-year-old male in the same identified health status. A 40-year-old woman is charged anywhere from 2 percent to 140 percent more than a 40-year-old man with the same health status for the same insurance policy.

What does my amendment do? It guarantees access to those critical preventive services for women to combat their No. 1 killers. We will provide these services at minimal cost.

The overall cost of my amendment has been scored by CBO. It says the cost is $1 billion. The majority leader, the Democratic leader, has provided opportunities to meet this cost. This amendment eliminates this big barrier of copayments and deductibles.

Let's talk about the benefit package. This benefit package is based on HRSA recommendations. It is based also on the recommendations of CDC. If this amendment passes, women will have access to the same preventive health services as the women in Congress have. If this passes, again, the women of America will have access to the same preventive services that we women in Congress have.

What does that mean? It means a mammogram, if your doctor says you need it; screening for cervical cancer, if your doctor says you need it; that check on diabetes, if your doctor is worried about you; and along with the symptoms related to menopause, there are other things, such as a loss of weight; and they may want to know at this juncture if you have diabetes. If you know that at 40, you are less likely to need kidney dialysis when you are 60.

The pending bill doesn't cover key preventive services, such as annual screenings for women of all ages to focus on our unique health needs. We know that for many people—for example, there are 15 million people in America with diabetes, and half are women. Often pregnant women with diabetes don't get the proper prenatal care. Heart disease is one of the top two leading causes of death in women—cancer and heart disease. Every year, over 267,000 women die from heart attacks. Women are generally unaware of their heart risks.

My amendment would, again, ensure heart disease screening for women. Remember that famous study that said ''take an aspirin a day to keep a heart attack away.'' It was done on 10,000 male medical residents, and not one woman was included. Thanks to a bipartisan effort, Bernadine Healy, NIH, and the women of the Senate, supported by the good guys of the Senate, were able to get that screening for women, get that evaluation. We know we manifest things differently than guys do. Now we are on our way to detection—if you can afford to have a doctor and if you can afford to have the screening.

My amendment also guarantees screenings for breast cancer—yes, for

mammograms. We don't mandate that you have a mammogram at age 40. What we say is discuss this with your doctor. But if your doctor says you need one, you are going to get one.

Studies have found mammogram screening decreases breast cancer among women by over 40 percent. Regular Pap smears reduce cervical cancer by 40 percent. This year, over 4,000 women will die of cervical cancer.

My amendment does focus on women's health needs. Keeping a woman healthy not only impacts her own life but that of her family. It impacts her ability to care for her child or an aging parent.

Early detection saves money by treating diseases early. Screening tests for breast and cervical cancer cost about $150, but the treating of advanced breast cancer is over $10,000 and can even go much higher. The treating of early stages of cervical cancer is $13,000 and can go much higher.

My amendment also leaves the decision of which preventive services a patient will use between the doctor and the patient. The health reform debate is focused on what you should have when. We agree. Decisions should be made in doctors' offices, not in the office of a Member of Congress or the office of an insurance executive. The decision about what is medically appropriate and medically necessary is between a woman and her doctor.

The authors of the bill have done a very good job in protecting women in many areas. This actually refines and improves this particular issue. That is why I support the overall health reform bill providing universal access to health care for over 90 percent of the American people, ending those punitive practices of the insurance companies, stabilizing and strengthening Medicare, and improving quality in public health by using innovation and preventive services and quality. We can pass a health reform bill.

I conclude by saying that we will end the confusion about what is needed in the area of preventive health services for women when our coverage is often skimpy and spartan. We want to make sure what we do enables us to have access to these comprehensive services.

I hope this amendment is adopted unanimously. I believe good people on both sides of the aisle will believe in its underlying premise: that early detection and screening save lives and save money.

Often those things unique to women have not been included in health care reform. Today we guarantee it and we assure it and we make it affordable by dealing with copayments and deductibles in a way CBO believes is fiscally achievable. In the long run, I think by doing this it will mean a lot to families, and it will mean a lot to the Federal budget.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, before I give a statement on the bill, I wish to compliment the Senator from Maryland for standing up for and essentially helping the health care of women. As she has pointed out, women are discriminated against today in America in various ways. Her amendment addresses some of that discrimination. I very much appreciate that. I know all women in the country do. I do, too. I have a mom. I have sisters. I have women in my family, and I very much care.

I don't know if she made this point, but about 80 percent of health care decisions made for families are made by women. It is all the more important women are not discriminated against, partly because they make so many decisions that affect health care for Americans, but second, women themselves are often discriminated against. Some States have gender ratings which discriminate against women. In other States a preexisting condition is a factor that discriminates against women.

I thank the Senator from Maryland. She has hit the nail on the head. It is another reason this health care reform is going to mean so much for so many Americans. I personally very much thank the Senator from Maryland.

In the Presidential campaign of 1912, Theodore Roosevelt's platform said:

> We pledge ourselves to work unceasingly in State and Nation for . . . the protection of home life against the hazards of sickness . . . through the adoption of a system of social insurance adapted to American use.

Today, nearly a century later, we are closer than ever to enacting meaningful health care reform.

As in Teddy Roosevelt's time, we seek protection against the hazards of sickness. Of necessity we seek a system uniquely adapted to American use. And recognizing the daunting task still ahead of us, we pledge ourselves to work unceasingly to get the job done.

In the years since Teddy Roosevelt, some of our Nation's greatest leaders signed up for this job. But at the same time, we have never faced a greater need to get the job done than we do today.

Why is that? Basically because health care costs are skyrocketing out of control. Every day American businesses are forced to cut benefits for their workers. Why? To remain competitive in the global marketplace. Every 30 seconds another American files for medical bankruptcy. Just think of that. Every 30 seconds another American files for medical bankruptcy. Every year, about 1.5 million families lose their homes because of health care costs. Our system is in crisis.

We have a historic need and we have a historic opportunity. We have an opportunity to enact groundbreaking reform that will finally rein in the growth of health care costs and help bring financial stability back to American families and businesses.

Unfortunately, there are some who stand in the way. Unfortunately, there are some who are spreading misinformation about how health care reform will work. On this very floor I have heard arguments that health care reform is about the government trying to take over health care. That is false.

The truth is, health care reform is about allowing patients and doctors to take back control of health care. We need to allow patients and their doctors together to take back control from the big insurance companies.

Our plan would not increase the government's commitment to health care. But don't just take my word for it. The nonpartisan Congressional Budget Office says:

> [D]uring the decade following the 10-year budget window, the increases and decreases in the federal budgetary commitment to health care stemming from this legislation would roughly balance out, so that there would be no significant change in that commitment.

That is right, health care reform will not increase the Federal Government's budgetary commitment to health care.

I have also heard it argued that health care reform will increase the budget deficit. That, too, is false—plainly, patently false.

The bipartisan Congressional Budget Office says our plan would reduce the Federal deficit by $130 billion within the first 10 years—reduce the deficit in the first 10 years. That trend would continue, the CBO says, over the next decade. During the next decade, CBO says our bill would reduce the deficit roughly $450 billion. That is nearly one-half trillion dollars in deficit reduction, according to the Congressional Budget Office, in the second 10 years.

I have also heard it argued that health care reform will raise taxes. That, too, is false. In fact, health care reform will provide billions of dollars in tax relief to help American families and small businesses afford quality health insurance—tax cuts.

The Joint Tax Committee—again bipartisan and which serves both the House and the Senate—tells us, for example, that our bill would provide $40 billion in the tax cuts in the year 2017 alone—$40 billion in tax cuts in the year 2017. The average affected taxpayer will get a tax cut of nearly $450. The average affected taxpayer with an income under $75,000 in 2017 will get a tax cut of more than $1,300.

Let me repeat that. The average affected taxpayer with income under $75,000 in 2017 will get a tax cut of more than $1,300. They will also get a tax cut in earlier years, but it ramps up to that amount in 2017.

In the same vein, I have heard claims that health care reform will result in an increase in higher costs for Americans. That, too, is false.

Health care reform will not result in higher costs for Americans. Health care reform is fundamentally about lowering health care costs and making quality health care affordable for all Americans. Lowering costs is what health care reform is designed to do, lowering costs; and it will achieve this objective. How? In many ways.

First, health care reform will end abusive practices by insurance companies. Reform will stop insurance companies from denying coverage or hiking up rates for those with a preexisting condition. We stop that in this legislation. That will lower costs. Reform will stop insurance companies from dropping coverage or reducing benefits for those who get sick.

Those reforms protect consumers, and they will protect Americans and reduce premium costs for Americans who are sick. These reforms will also help lower costs for small businesses and their employees. Right now, if one employee in a small business gets sick—just one—insurance companies can double the premiums they charge the whole business. I know that is true. I have heard that time and time again from small business owners in Montana. That is just because one employee gets sick, the insurance companies jack up premiums, double the premiums they otherwise would charge the whole business. That is just wrong. We stop that in this legislation.

How else do we lower costs in this bill? Health care reform will provide billions of dollars in tax credits and reform will limit out-of-pocket costs such as copayments that insurance companies are able to charge. We limit them. This will also help to ensure Americans can afford their total health care costs and not just their premiums.

That is very important. Premiums and out-of-pocket costs are both addressed by this bill. It limits growth in premiums and also limits growth in out-of-pocket costs. So total cost—premiums plus out-of-pocket costs—for Americans will be lower under this legislation than otherwise would be.

Third, health care reform will work to repeal the hidden tax of more than $1,000 in increased premiums that American families pay each year in order to cover the cost of caring for the uninsured.

Today, millions of Americans without health insurance are too often forced to turn to emergency rooms to get the care they need, and then health care providers shift the cost of that care to other Americans with health insurance. People with insurance, therefore, pay higher premiums. By providing quality, affordable health insurance to millions more Americans, health care reform will reduce this hidden tax and reduce premiums for all Americans—$1,000 per year per family due to uncompensated care. That is that hidden tax. This bill will virtually stop that hidden tax, stop that additional $1,000 that goes to average family premiums.

How else do we reduce health care costs? By providing affordable health care to more Americans which will increase the number of Americans in the insurance market. Why? What is so good about that?

One reason is more people will have health insurance. But also it will spread the risk of paying for an accident or disease more broadly. Spreading the risk more broadly should lower premium rates for everybody. It is a basic tenet of insurance.

Fifth, health care reform will reduce costs by cutting administrative redtape. That is no small item. Today, insurance companies spend a lot of time and money finding ways to discriminate against people. They spend time and money to find ways to drop coverage, and insurance companies pass those administrative costs on to all Americans in the form of higher premiums. The figure I heard is about 18 percent of American health care dollars is administrative costs. This legislation would dramatically reduce that percentage to a much lower number. We don't know to exactly what level yet but a much lower level. About 18 percent of total health care dollars go to pay administrative costs. That is not the case in other countries. They pay 4 to 5 percent in other countries. We have to get that down in America, and health care reform will significantly achieve that result.

Health care reform will outlaw this discrimination, and also reform will eliminate those administrative costs that go along with it. Furthermore, health care costs will work to streamline administrative procedures across the board by requiring standard enrollment forms and marketing material through insurance exchanges. That, too, will help streamline procedures. That, too, will help reduce administrative costs for providing for standard enrollment forms and also standard marketing materials through insurance exchanges. That is going to lower administrative costs and make it much easier for a person to shop and know which policy is best for him or her. With the other reforms we are making competition is more on the basis of price not just underwriting, a fancy term for denying because of a preexisting condition and putting in all those extra escape clauses insurance companies often provide in small print. In a letter released today, the Congressional Budget Office said:

> Compared with plans that would be available in the nongroup market—

And they are referring there to the individual market—

> under current law, nongroup policies under the proposal would have lower administrative costs.

Let me say that again. Compared with plans that would be available in individual markets—individuals seeking insurance—under current law, individual policies under the proposal would have lower administrative costs.

Lower, not higher. Lower.

Six—another way to reduce costs. Health care reform creates insurance exchanges where consumers can easily shop and compare plans to find the right coverage. Exchanges will make it easier for Americans to choose the most efficient plans, and that will reduce their costs and put pressure on insurance companies to offer lower cost, higher quality plans.

Seven—still another way this bill reduces costs. Small business insurance exchanges will allow small companies to pool together to spread their risk and increase their buying power. More pooling available for small business insurance exchanges—this will allow small businesses to negotiate lower rates and provide more quality insurance plans with lower premiums to their employees.

Eight. Health care reform will strengthen oversight and enforcement measures to cut down on fraud, waste, and abuse in the health care system. Fraud, waste, and abuse are estimated to cost our health care system more than $60 billion every year. This bill will help reform our system to reduce fraud, waste, and abuse, which eats up way too many health care dollars.

Nine. Health care reform will move the focus of our system toward efficiency and value with payment incentives that reward quality care—not quantity and volume but reward quality care, reward outcomes. Over the long run, paying doctors and other health care providers for quality instead of quantity will reduce health care costs.

Ten. Health care reform will lower costs by working to change the focus of our health care system from treating sickness to promoting wellness. The big problem we have today is that we treat sickness. We don't spend enough time promoting wellness. Reform will make critical investments in policies that promote healthy living and help prevent costly chronic conditions that drive up costs throughout the system.

These are just 10 examples of how health care reform will reduce health care costs and lower premiums for American consumers. There are many more, but these are those 10, as I said. On the other hand, without reform; that is, without passing this legislation, costs are guaranteed to continue to skyrocket out of control.

Since Congress failed to enact health care reform in the 1990s, health care premiums have risen eight times faster than wages. Consider that. Since the last time we attempted to pass health care reform—and failed—in the 1990s, health care premiums have risen eight times faster than wages. And if we don't reform our health care system now, premiums will increase 84 percent in the next 7 years. And that is just premiums. What about out-of-pocket costs? Those, too, will increase at a rate much faster than wage increases.

Today, health care coverage costs the average American family more than $13,000 a year, according to the Kaiser Family Foundation. If current trends continue without reform, the average family plan will cost more than $30,000 a year in the next 10 years. That is up from $13,000 today to $30,000 10 years from now. And businesses could see their health care costs double in that same time. Without reform, our Nation's long-term fiscal picture is almost certainly unsustainable.

As Peter Orszag said when he was Director of the Congressional Budget Office:

Rising health care costs represent the single most important factor influencing the Federal Government's long-term fiscal balance.

He was right. Without reform, instead of working to reduce our national deficit and stabilize the Federal budget, we will see total health care spending nearly double to encompass one-fifth of our gross domestic product in less than 10 years. And the Congressional Budget Office projects entitlement spending will double by the year 2050.

Without reform, millions of uninsured Americans will continue to suffer. A Harvard study found that every year in America, lack of health care coverage leads to about 45,000 deaths. People without health insurance have a 40-percent higher risk of death than those with private health insurance. You have a 40-percent higher chance of death if you don't have health insurance compared with those who do. That is 46 million Americans at risk today because they do not have health insurance. A recent Johns Hopkins study found that children without insurance have a 60-percent higher risk of death than those with private health insurance—a 60-percent higher risk of death than those with private health insurance.

Another recent Harvard study found that the risk of dying from car accidents and other traumatic injuries is 80 percent higher for those without insurance—80 percent higher. The risk of dying from car accidents and other traumatic injuries is 80 percent higher if you don't have health insurance. In the greatest country on Earth, no American should die simply because they do not have health insurance.

So, Mr. President, we are at a crossroads in history. We have a historic opportunity to enact meaningful health care reform that will work to stabilize our economy and provide quality, affordable health care coverage for millions of Americans. We are not the first to be here, but we have come further than ever before.

We laid the groundwork in the Finance Committee and the HELP Committee. We held many hearings and countless hours of meetings on health care reform. Each committee crafted meaningful legislation and held exhaustive markups where we incorporated amendments from both sides of the aisle. We produced balanced, meaningful legislation, and I am proud—I am very proud—of the work both committees accomplished. Now we have one health care plan before us in the Senate, two basic bills merged together. We have an opportunity to debate that plan and offer amendments to make it even better. Then we will be called upon to vote.

The health care of our Nation is depending on us. The health care of our economy is depending on us. History itself is depending on us to answer the call. I am confident we will. I am confident we will at long last answer the call of history. I am confident we will soon enact meaningful health care reform that will lower costs and bring quality, affordable coverage to millions of Americans.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. Mr. President, as I mentioned earlier following the unanimous consent requests the leader made—who then introduced Senator MIKULSKI so that she could do her amendment, which kept me from commenting on the unanimous consent requests he made—I have to say I think those unanimous consent requests would have to be put in the category of a stunt. Unanimous consent usually means the two leaders have gotten together and negotiated some kind of agreement that we would abide by during this time. There was no agreement on this. Yet they went ahead and did the unanimous consent request solely so they could get the objection.

Nobody here, I am sure, wants to use Social Security money for anything except Social Security. So the real key to the stunt was the second one, which is the net savings generated by the CLASS program. That is a long-term care program that wound up in the Health, Education, Labor, and Pensions Committee bill.

The flaw with that particular amendment was that it collected money for 10 years without spending any and then it wound up with a huge liability. So we put in a little provision that it had to be actuarially sound because, quite frankly, it is not very good accounting to collect $70 billion in exchange for a $2 billion—excuse me, $2 trillion—I get the b's and the t's mixed up here, because we are talking about real money here—a $2 trillion bill. That is how much we are going to have to pay out over the next 10 years to cover the $70 billion we accept in payments for this new kind of insurance that would be provided. That kind of insurance is provided—it is provided in the private sector—but for considerably more than what they were providing for in the CLASS Act.

So that was to bring a little more attention to it, and I want to bring a little more attention to it because I want people to take a closer look at the way that winds up. It is a good idea that is not paid for, and it is not paid for in such a way that it winds up, once again, adding to the deficit but in some cagey ways.

As for having the amendments posted on the Web site before they are given, I hope the initial version is posted on the Web site by everybody before they do it. But one of the things that happens on this floor is that occasionally a good idea can be built on by somebody from the other side or even somebody from your own party, and when that happens you can modify the amendment. I am not sure that agreement wouldn't have prohibited any modifications to amendments, which is kind of what we ran into in the Finance Committee when we were trying to do amendments.

So good ideas—they need a lot more work. And to just throw those out at the beginning and to have about 1½ minutes' notice that they are going to be thrown out—I just don't think that is the right way to go about this whole process.

I have been working on the Nation's broken health care system ever since I entered the Senate more than 12 years ago, and I had high hopes this would be the year the Democrats and the Republicans of the Senate would work together to provide health insurance to every American. I urged my colleagues to start with a blank piece of paper and develop a bipartisan bill that up to 80 Members of the Senate could support.

Unfortunately, the majority leadership had other ambitions, because the bill being debated today is a testament to a partisan ideological vision. It appears that the drafters of this bill took to heart the sentiments expressed by the Speaker of the House, who earlier this year said, ''We won the election, we write the bills.'' And for a number of weeks, the majority leader closed his door and wrote this bill on his own terms without any input from many of his colleagues or anybody on this side of the aisle.

This is a deeply flawed bill that fails to address the real needs of the American people. Americans overwhelmingly want reforms that will help lower their health care costs. Instead, this bill will spend $2.4 trillion when it is fully implemented and contains numerous provisions that will actually drive up the costs millions of Americans pay for their health care.

It is important to understand how we got here. At the beginning of this process, the majority staff of the HELP Committee decided they were going to draft a partisan bill based on the reforms that had recently been adopted in Massachusetts. Republicans were shut out of the process during the drafting of the HELP Committee bill. Rather than working to resolve the difficult issues, the drafters of the bill included over 200 separate instances where the bill gave the Secretary of Health and Human Services the authority to make important decisions about the types of health care plans millions of Americans can receive. Rather than confronting and debating these important policies—getting to the details, and the devil is always in the details—the majority empowered unelected government bureaucrats to make decisions that will affect the health care of every single American.

As a result of this partisan process, we were forced to file hundreds of amendments. The chairman and other Democratic members of the committee have repeatedly commented on the numerous amendments accepted by the majority during the markup. At the

same time, they ignored the reality that most of these amendments were merely technical corrections which were necessary because the underlying bill was hastily written and filled with numerous drafting errors. Unfortunately, nearly all of the accepted Republican amendments merely tinkered around the edges. Almost all of the substantive alternative-idea amendments suffered the failing fate of the party-line vote. In 12 days of markup at HELP, we had 45 rollcall votes on Republican-sponsored amendments and only 2 prevailed.

After the markup, the majority refused to release a final copy of the bill for over 2 months, denying the American people the chance to see what they had done. Once we finally got a copy of the bill, we learned that majority staff had unilaterally made numerous changes to the bill, in some cases undoing agreements that had been worked out by Members on issues such as prevention and wellness.

While this was happening, there were also ongoing bipartisan negotiations, led by Senator MAX BAUCUS. And I have to congratulate him for the process he started and got people involved in and for his persistence and the amount of time he put into it. This dwindled down to a Gang of 6. The Gang of 6 discussions were not an honest attempt to try to develop a bipartisan health care bill that would offer real solutions to the problems that face our health care system.

Ultimately, these negotiations failed to produce a bipartisan bill. I do not believe the failure was due to a lack of effort on the part of the participants but, rather, we were unsuccessful because the Democratic leadership chose to impose arbitrary and unrealistic time deadlines on the process that we commented on. The deadline slipped a few times, moved up a week, and then became finalized. The decision was made that it was more important to move fast than it was to get it right, and the decision ultimately doomed our efforts.

This, in turn, led to another partisan markup where the Finance Committee rejected most GOP health reform ideas. Proposals such as medical liability reform were rejected on jurisdictional grounds, while the chairman unilaterally included Democratic provisions that were clearly within the jurisdiction of other committees. Republican amendments were voted on and then unilaterally changed at the eleventh hour—actually, 1:30 in the morning—by amendments offered by the chairman.

The two bills were then merged, merged in secret, with no input from the many Republicans who want to enact a bipartisan health bill. We now have a 2,074-page bill that reflects many of the worst provisions from both the HELP and the Finance Committee bills.

We did not need to end up here today with Republicans opposing a partisan health care reform bill. The Senate should develop legislation that will impact one-sixth of our Nation's economy and affect the health of every American.

The former chairman of the Senate Finance Committee, Daniel Patrick Moynihan, a Democrat from New York, once provided the following perspective on how the Senate should consider major policy changes. He said:

> Never pass major legislation that affects most Americans without real bipartisan support. It opens the doors to all kinds of political trouble.

Chairman Moynihan noted that absent such bipartisan support, the party that didn't vote for it would feel free to take shots at the resulting program whenever things go wrong and a large segment of the public would never accept it unless it was an overwhelming success. Chairman Moynihan understood a partisan legislative process guarantees that any glitches that occur in implementing the bill would provide ammunition for future attacks; thereby, further undermining public support of the new policies. There will, unfortunately, be plenty of glitches if this bill is ever enacted.

The Reid bill will impose $493 billion in new taxes, and many of them go into effect immediately. At same time, most Americans will not see any insurance reforms or other potential benefits from this bill until at least 2014. That leads to some interesting accounting.

The Reid bill will kill jobs and cut wages. The Congressional Budget Office has told us the employer mandates in this bill will likely result in lower wages and higher unemployment. These job and wage cuts would hit low-income workers, women, and minorities the hardest. It is hard to believe that with unemployment at a generational high, Democrats would even consider putting more jobs on the chopping block. The Reid bill mandates that Washington bureaucrats ration care. The bill lays the groundwork for a government takeover of health care, giving Washington bureaucrats the power to prevent patients from seeing the doctor they choose and obtaining new and innovative medical therapies.

I think that is attested to by the first amendment we have, the amendment by the Senator from Maryland, because her amendment preempts the provision in the bill that allows the U.S. Preventive Services Task Force to determine what preventive services should be covered. This amendment recognizes the problems associated with government bureaucrats determining what benefits should be covered. The majority realized it had a political problem when the U.S. Preventive Services Task Force said that women aged less than 50 years old should not have annual breast screening exams. This amendment doesn't do anything to protect patients who might be denied access to preventive tests in the future, such as prostate exams, colonoscopies, Pap smears, and so on, if bureaucrats decide to deny access.

This bill also shows how this will never be a truly science-based process. Bureaucrats will always have to respond to political pressure for powerful constituencies.

I guess we are part of the powerful constituencies. If we decide something should or should not be in there, that eliminates the science-based part of it.

I understand what they are trying to do. In the HELP Committee, when we were doing the markup, we did numerous amendments around this clinical effectiveness research, to see what it was supposed to eliminate from the health care for the person, separating them from their doctor by making these science-based decisions.

We did a series of amendments and found there, evidently, are a lot of things they are hoping will be precluded from people being able to get. I invite people to take a look at those amendments. We may have to try those again to see exactly where this process is going. I appreciate the Senator from Maryland making an attempt to solve a part of the problem, but I am having a little trouble with the reading of the amendment itself. At any rate, enough of that.

The Reid bill spends millions—billions. There is that word again. The Reid bill spends billions of taxpayer dollars on new pork-barrel spending. The bill would build new sidewalks, jungle gyms, and farmers' markets and creates a $15 billion slush fund for additional pork-barrel projects, a real deviation from what the Appropriations Committee has ever allowed.

This bill also fails to achieve the commonsense goals Republicans and Democrats share. This bill even breaks many of the promises President Obama has made about health care reform. President Obama repeatedly called for a health care bill that will reduce costs. This bill will actually drive up health care costs for millions of Americans as a result of new mandates and taxes. President Obama has also said that if Americans like the insurance they have, they can keep it. Under the bill, millions of Americans will lose their employer-provided health insurance.

President Obama promised not to raise taxes on individuals earning less than $250,000 per year. The bill would impose several new taxes on people who make considerably less than $250,000 a year.

President Obama said the health care reform would not increase the deficit. This bill will not increase the deficit only if you believe certain things. This bill will not increase the deficit if you believe Medicare payments to physicians will be cut by 40 percent over the next decade. I don't think anybody believes that.

The bill would reduce the deficit only if you believe Medicare payments to other providers will be slashed to levels that endanger patients' ability to get the care they need. No one believes that.

The bill will also reduce the deficit if you believe Congress will allow a massive new tax to be imposed on middle-class tax payers. I hope no one believes that.

If you don't believe Congress will allow all these things to happen, then you can't believe this bill will reduce the deficit. President Obama, in his remarks to the American Medical Association this summer, acknowledged the need to address our out-of-control medical liability. Rather than addressing this issue, this partisan bill preserves the costly, dangerous, duplicative medical malpractice system.

President Obama finally said no Federal dollars will go to pay for abortion. According to the National Right to Life and the Conference of Catholic Bishops, the Reid bill fails this requirement as well.

Despite all these failures, it is still not the worst health care bill in Congress. The Wall Street Journal got it right when they described the House-passed bill as the worst bill in America. Even if the Senate passed the bill before us today, it would still have to go to conference with the House bill and any final bill would have to move toward several provisions in the House bill and poll after poll suggests that the American people are opposed to this bill, let alone the wild one from the House.

If we cannot defeat this partisan bill and get back to work for the American people and write a bill that garners the support of both parties, doing it step by step so we can assure, for instance, the seniors that Medicare money will only be spent on Medicare—that is one of the pieces that ought to have been in that unanimous consent I started talking about. That is not going to happen, though. They are going to take a bunch of money out of there.

I think this legislation fails to meaningfully address these goals and will stick the American people with a bill we cannot afford. I believe we can do better, and we owe it to the American people to do so.

I yield the floor.

The PRESIDING OFFICER (Mrs. HAGAN). The Senator from Connecticut is recognized.

Mr. DODD. Madam President, let me begin, if I may, by congratulating the majority leader and my colleague and dear friend from Montana, Senator BAUCUS, and members of the Finance Committee as well as the members of the HELP Committee. As I said before, I am sort of an accidental participant in all this, in the sense that the person who should be standing at this desk and at this podium as the chairman of the HELP Committee is, of course, our deceased colleague from Massachusetts. I was filling in for him during the months of his illness and managing the markup of the bill that produced part, half—whatever the percentage is—of the combined legislation. All our colleagues know, whether you agreed or disagreed with him, he considered this issue to be what he called the passion of his public life, to make a difference for all Americans when it comes to their health care. So I know it is with a sense of sadness that, on the day on which we begin this historic debate and discussion, he is not here to participate—at least physically. We sense his presence, of course, those of us who had the privilege of serving with him for so many years, as Senator BAUCUS and I did, and worked with him on these many issues. Of course, our colleague from Wyoming, Senator ENZI, and Senator GRASSLEY did as well over the years. I thank all members of the committee.

It was a laborious undertaking. The Presiding Officer was very much a part of that as well, during those many hours we gathered in the Senate caucus room—the Russell caucus room now named the Kennedy caucus room—in some 23 sessions, over many hours. But that was only the culmination of an effort that began a long time ago.

Actually, the business of writing this bill began months and months earlier. My colleague from Montana can appreciate the hours I know I spent in meetings in his office, late into the evening, long before a markup began. Long before any formal conversations and discussions, there was a significant reaching out to our colleagues, to try to bring us together and develop what we all hoped to be the case and still can be the case; that is, a consensus bill, a bipartisan bill on health care.

I know as a matter of fact here, beginning last fall, Senator Kennedy, when he did have his strength, met on countless occasions with members of the minority to try and navigate the minefield of health care ideas, to see if it couldn't be possible to put together that kind of a consensus bill.

I know our committee began a long process, beginning last winter, to try to begin, long before the markup of this summer, to draft such a proposal, having what they call a walk-through of legislation, going through the various ideas and listening.

It was with some regret that I say this idea that the bill somehow being jammed down people's throats, with little or no thought given to other people's ideas and thoughts, is not borne out by the facts. I have been here for many years. I have been through many markups over three decades in this body on various committees. This effort was and still remains an effort to try to bring us together about this issue, which has such a massive impact on not only the individuals of our Nation who go through the fear every day of wondering whether the coverage they have will be adequate; and if they don't have that coverage, whether an illness or tragedy could befall them that could wipe out everything they have—not only today but for the rest of their lives.

This journey begins. My hope is, before we have finished the task, we will find that common ground that we each bear responsibility to try and achieve.

Before we left for the Thanksgiving holiday, the Senate held a landmark vote on whether we should even debate health care. I must say a lot of attention was given to that. There must be a lot of confusion in the minds of many Americans, wondering why we had to debate whether we could debate. The one issue this body is known for is endless debate. We are not limited, under our rules of the Senate, at least not formally limited, by how much time we can consume when we want to talk. The filibuster is a unique practice which only the Senate has. So we had to vote as to whether we could actually have a vote. We had a debate on whether we could have a debate on the subject matter that is obviously of great concern, whether you agree or disagree.

I think all Americans agree the present system needs a lot of work. The vote we took simply stated that after decades of inaction, despite the efforts of others over the years, this time the Senate would not fail to deliver the change the people we represent across America want and need.

We now begin that long, overdue conversation over exactly what change should look like in the area of health care. There are, as has been made clear over the past months, many different opinions on the subject matter, almost as many as there are Members of this body. I hope my fellow Senators are ready to share their thoughts, listen to the ideas of their colleagues and, most importantly, join together to act. The legislation we present for debate is designed to fix the things that are wrong with our system, while protecting and strengthening the things that are great about health care in America. As I have heard my colleague from Montana say on so many occasions, we are not out here to design or copy what goes on in Canada or Europe or Australia or New Zealand or any other country around the world. We are here to design an American health care plan, an American plan, one we are forging after listening to health care providers, our constituents, and others who have great interest in the debate and discussion and who bring very valuable facts to the table, as all of us, individually, even those not on the committee, have listened over many weeks and months—in fact, over many years that we have been debating this subject matter.

Our long history of innovation and discovery—cures, vaccines, and treatments, discovered and produced right here in our own country, that have saved countless lives here and around the world—is something for which every American ought to be proud. Our legislation, this combined bill, encourages that innovation so more groundbreaking medical discoveries can be made in America.

In fact, one of the debates that occurred in the HELP Committee, as my colleague and the Presiding Officer may recall, was on an amendment offered by Senator HATCH—no technical

amendment—dealing with how to create a pathway for the Food and Drug Administration to approve follow-on biologics and how many years of exclusivity innovators should receive for their original product. We had a heated debate in the committee. It went on for a day or so. In a divided vote, the Hatch amendment was approved with bipartisan support for this very critical and important issue. No technical change, I might add, a significant part of this bill.

Our legislation recognizes that we do best by our citizens when the public and private sectors work together. It has been our history in so many areas, not just in this area.

Medicare, the ironclad commitment to take care of our seniors, dating back to 1965, when Members who preceded us in this Chamber, in a heated debate that went on for days, heated debate over whether we would have a health care program for seniors, decided not on a partisan vote but nearly as much, that there ought to be something called Medicare. It took the poorest sector of our population, the elderly, and lifted them out of poverty. Because we said: After their works on behalf of all of us, their defense of our Nation in two world wars, and their contribution coming out of a depression, we ought to be able to do better by them when it comes to their health care needs, Medicare was established. And despite what some critics have said, this legislation protects and strengthens Medicare. I hope even our friends who have taken to labeling government-run programs such as Medicare as socialist takeovers will join us in keeping this important promise to our seniors.

Of course, Americans are justifiably proud of and happy with our workforce of dedicated health professionals, the doctors, specialists, primary care physicians, compassionate nurses, dedicated medical technicians, and family doctors all across the Nation who make a difference every single day in serving the people of our Nation. This legislation is designed to guarantee that you can get the care you need when you need it from the doctor you like. Meanwhile, it will help that physician spend less time filling out redundant paperwork and more time taking care of you and your family. It will help you spend less time fighting with your insurance company and more time getting better and getting back on your feet again.

There are many things to like about our health care system in the United States. This legislation doesn't change them. There are many things that are wonderful about our health care system. I think it is important at the outset to acknowledge that and to understand, again, the quality of innovation that occurs, the compassionate work done by health care providers in every community. In my State, there are 31 hospitals, all nonprofit hospitals, in the State of Connecticut. I have visited all of them over the years, but I have gone back recently and almost completed a round of going to see them all about this bill, sitting down with rural hospitals in northeastern Connecticut to major urban hospitals in Bridgeport and Hartford. I wish I could take everyone with me to see what everyone does. I know this is the case in other States where people do a remarkable job every day. If you show up in a hospital, they treat you. No one gets turned away. It is a wonderful thing about our health care system, the people who work in them every single day, reaching out to try and make a difference in the lives of these individuals, and how frustrating it is for these health care providers.

I met with a group of ophthamologists in Hartford. One doctor was telling me how a family came to him the other night with a child that clearly needed a medical device and technology and knowing what a difference it could make for her. Yet that insurance company said: No, you can't do it; we don't provide that kind of coverage. The frustration that doctor expressed because he couldn't provide what that family needed. They didn't have the resources financially to pay for it, and they were being turned down. That child could not get that help. Under our bill that won't happen, if we can get this legislation done. Examples like that child happen every day across this great country of ours.

The high cost of health care has bankrupted millions of families. The system, in many ways, despite its strengths, is broken in too many places as well. Without reform, health care will continue to eat up larger and larger shares of budgets—the Federal budget, State budgets, business budgets and, of course, family budgets. Budgets, particularly family and business budgets, are at breaking points. The high cost of health care has bankrupted millions of families, shuttered the doors of businesses, forced States to make impossible choices, and put unimaginable strain on the Federal bottom line. If we don't address the skyrocketing cost of health care, more and more families, more and more businesses could lose everything and our deficit will explode. As bad as it is today, it gets worse if we do nothing.

That is the bigger picture. But the reality of our broken system can be captured by the tragedies that play out in American homes every single day. As we have discussed, tens of millions of our fellow citizens who don't have health insurance at all go to bed every single night knowing that if they wake up sick or their children wake up ill or in need of medical care, they might not be able to see a doctor to get the medical care they need. Many of these Americans don't have insurance because they can't get insurance, they have a preexisting condition, and no insurance company wants them on their rolls.

There are even more Americans who do have insurance but can't be sure of anything these days when it comes to their health care. They are paying more and more in premiums, twice what they paid even a decade ago. Yet they are getting less and less and less coverage for their money. They lie awake at night wondering, what if I lose my job, as many have over these last number of weeks and months, what if I get sick and find out my policy doesn't cover the care I need or, even worse, my insurance company cancels my policy altogether. What if I run out of benefits and have to pay out of my pocket. These are not irrational fears. They are anything but irrational fears. Millions of our fellow citizens have them every single day, and these nightmares come true for far too many of our citizens. People lose their homes because they get sick. People die because they can't afford care.

This does not happen to the 8 million of us who are Federal employees, all of us who serve in this body and the 435 who serve in the other body. Like all Federal employees, we have a special marketplace. Every year each one of us gets to choose from a long menu of insurance options. We sit down. We pick a plan that makes sense for us and our families, and we know the coverage we have chosen will be there when we need it. Every American should have the same opportunity as the people who represent them in the Halls of Congress. That is what our bill tries to do.

For too long health insurance has been a seller's market. Depending upon where you live, you may or may not have more than one option or two options to choose from. Sometimes there aren't any good options at all. You pay whatever the insurance companies want to charge you, and you get whatever coverage they feel like giving you. You are covered only until they decide they don't want to cover you any longer. By the way, if you lose your job, or if you want to change your job, if you want to start a business, if you want to move, you could lose your coverage entirely.

Our bill is designed to help you get a better deal and empowers every American family to pick the plan that works for them, creating a real marketplace, like the one Federal employees have, that members of congress have, with multiple insurance companies competing for your business and a real choice for you and your family. If you like what you have now, great, keep it. If you don't, you will have more and better options to consider. If you are one of the millions of uninsured Americans who has been denied coverage because of a preexisting condition, you will immediately have access to affordable coverage so that you will have insurance while this marketplace is being established. In that marketplace, you will finally have a chance to find affordable insurance that works for you and your family. No matter who you are or which plan you choose, you will have less expensive options. Insurance will be available regardless of your age or your health. And once you

have it, the insurance company won't be allowed to take it away. You stay covered even if you lose your job, even if you move, even if you get sick.

On the day this bill is enacted, health insurance becomes a buyer's market, not a seller's market. That is as American as apple pie, having choices, good old competition out there. So little of it exists today. Our bill is designed to promote and create more of it. When businesses have to compete for your business, we all do better. Businesses do well and, obviously, the consumer has better choices. As other pieces of the legislation begin to take effect, our health care system will become less expensive and more responsive to the needs of the American people. Because American families and businesses literally can't afford more of the status quo, our bill makes health care more affordable.

According to the Congressional Budget Office, if you are buying health insurance in the individual market under the senate bill, premiums may be up to 20 percent lower than equivalent coverage today. According to CBO, if you are buying health insurance in the individual market, you could see premium costs be as much as 20 percent lower than what they are today. If you are working for a small business, according to CBO, your premiums may be up to 11 percent lower than what they are today. And according to the Congressional Budget Office, if you work for a large employer, which five out of six Americans do, your premiums could be lowered by as much as 3 percent. In every single category—individuals, small businesses, as well as large employers—premium costs come down under our bill, according to the Congressional Budget Office.

Compare that to the status quo of doing nothing or defeating this bill. I can't speak for every State, but I suspect these numbers are probably pretty much true across the country. In Connecticut, in the year 2000, a family of four paid on average around $6 to $7,000 a year in health care premiums. Today that same family in my State, 9 years later, is paying over $12,000 for that same coverage. And if we do nothing in the coming days, those numbers will jump to around $24 to $25,000 in 7 years and as much as $35,000 in 10 years.

Compare that with what we offer here in this bill. The CBO says we can actually lower premium costs in the individual market, the small group market, and the large group market. That is what is in this bill. That is why it is deserving of our support.

Because investing in keeping people well is more cost effective than waiting to treat them when they get sick, this legislation puts a focus on prevention. Let me pay a particular tribute to Senator TOM HARKIN, now chairman of the HELP Committee, who spent a long time on the prevention piece of this bill, as I know the Finance Committee did as well, combining efforts to encourage more effort in reducing the tremendous problems that are associated with four or five illnesses that consume about 70 or 75 percent of the health care dollar. You can't wipe them out altogether, but by working on prevention, dealing with obesity, smoking, cardiovascular problems, you can make a difference in those areas alone.

I know my fellow members of the HELP Committee, we passed legislation—and my good friend MIKE ENZI was a part of this and a strong supporter on the floor of this body—when for the first time in America history, the Food and Drug Administration can now regulate tobacco products. They can regulate mascara, cat food, dog food, men's cologne, all of those things get regulated, but tobacco did not. We changed that. We finally have regulation of the sale, marketing, and the production of tobacco products by the Food and Drug Administration. That is $180 billion a year in health-care related costs. Four hundred thousand people die every year from smoking-related products; 3,500 young people today will start smoking in the United States; 1,000 will become addicted for life, 3,500 a day just in that one area. If we can reduce people's dependency on those products, if we can get people to quit, if we can stop children from starting in the first place, what a difference that can make for people all across the country. From diabetes screenings to quit smoking programs to mammograms, you will be able to get preventive care at no cost to you under this bill. That we do right off the bat so you can stay well even if your family is not wealthy.

Because our seniors should be able to afford the prescriptions they need to stay healthy, this bill will shrink the Medicare Part D doughnut hole, giving seniors a 50-percent discount on medications. That is a huge savings to our people. Because 200 million American adults don't have insurance protection in place to handle the cost of long-term services and supports, our bill creates a new program that will give American families peace of mind, help working people who are also taking care of a loved one, and save Medicaid dollars in State and Federal budgets.

Because we need our small businesses to do what they do best—create jobs—our bill alleviates their burden by providing a tax credit to help them cover the cost of providing health care to their employees, as so many of them want to do. And because a buyers' market depends on educated buyers, our bill will empower consumers by eliminating the fine print in insurance policies. You will be able to make an apples-to-apples comparison when shopping for health insurance.

Again, according to the Congressional Budget Office, families and businesses will save money because this new marketplace will bring down administrative costs, ensuring you get the most out of your premium payments and increased competition for your business—competition that is increased even further with a strong public option as well.

The analysis confirms that if you like the plan the way it is, the bill explicitly provides that you will be able to keep it. In fact, just so we are clear, let me quote from the CBO, the Congressional Budget Office, analysis released today. I quote them:

> [I]f they wanted to, current policyholders in the nongroup market would be allowed to keep their policy with no changes, and the premiums for those policies would probably not differ substantially from current-law levels.

The CBO estimates that as the marketplace gets up and running, the deficit will go down by $130 billion in the first 10 years after this bill passes and by $650 billion more in the second decade.

This bill lets you keep your insurance if you like it, this bill protects seniors, this bill gives families more choice, and this bill saves money.

While I hope we can keep our facts straight, let me say at the outset that I expect this to be a full, open, and at times passionate debate in this Chamber, as it should be. This is an issue that represents a full one-sixth, as you have heard already, Madam President, of our economy, and it affects every single one of our citizens. Still, I understand that no matter how patiently and thoroughly we discuss this issue, some will, of course, insist we are attempting to rush through a piece of partisan legislation. Again, let's get our facts straight. Thus far, between the two committees responsible for drafting this bill, we have held more than 100 bipartisan meetings, devoted more than 20 days toward the amendment process, considered more than 400 amendments, and, despite what I have heard, we accepted 170 amendments offered by the minority, including some very substantive ones. Clearly, there were technical ones. I am not suggesting otherwise. But to suggest that all of these were such is not to portray an accurate picture of what occurred. The legislation we will now debate was made available online 72 hours before even a procedural vote was cast.

Well, Madam President, I am committed to ensuring every Senator has the opportunity to offer his or her suggestions. That is what we did in our committee. It took a long time. But while people may not have been happy with the final outcome, I believe people ought to have an opportunity to be heard and their ideas to be vetted here and to engage, I hope, in a civil debate, a passionate but civil debate, not to engage in the ad hominem personal attacks that too often have contaminated debate but, rather, you ought to stand or fail based on the soundness of your ideas.

My dear friend Ted Kennedy spent a lifetime, as I said at the outset of these remarks, fighting for every American's right for decent health care. It is a cause I know we all support. This is our chance to get it right.

This moment calls for commonsense problem-solving that cuts the cost of health care, protects patient choice, and ensures every American gets the care they need when they need it, from the doctors and providers of their choice.

This moment calls for compassion. We must finally hear the cry of the child whose ear infection goes untreated because his or her parents cannot find jobs and cannot afford a doctor; the voice of the small business owner who must choose between laying off workers and cutting off health benefits for them; the call of future generations who will see the rising tide of health care costs become a tsunami if we do not act in these days.

Perhaps most of all, this moment calls for courage. This bill does not necessarily guarantee a tickertape parade or a lot of applause lines. There are some very tough choices in this bill.

With the possible exception of the public option and a few other items, I suspect that if the roles were reversed here and we were sitting in the minority and our friends on the other side were in the majority, frankly, the bill we would be considering today might not be substantially different because, frankly, the options are not unlimited as to how to deal with costs and increased access and prevention. Yes, there are differences. I accept that and understand that. But the kinds of choices Senator BAUCUS and his committee made, and the ones we considered in our committee, were ones I believe most of my colleagues believe generally have to be dealt with: the quality of care, strengthening our workforce, dealing with the delivery system, increasing prevention and wellness in this country. What steps do we take? We can differ over this item or that, but I believe we generally believe these are items that must be part of a significant health care proposal. So I suspect these bills, were the roles reversed, might not be substantially different. It might not be that different.

Perhaps most of all, it is important we find the means to come together. The road we are on, the status quo, leads to ruin, in my view, for our economy and for our fellow citizens. The road to reform is a long and difficult one, but we have taken so many unprecedented steps just to come to this place. It is time now to finish the job.

So I am prepared—as I know our leader is and as I know my friend from Montana, the chairman of the Finance Committee, is, as are the members of that committee, as I believe most of our colleagues here—we would like a legacy to be left long after we have departed this Chamber that will say that in the first decade of the 21st century, when faced with the daunting challenge of doing something positive to increase the availability, increase the quality, and decrease the cost of health care in America, this Congress rose to the challenge and met its obligations. I feel optimistic we can achieve that.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I have a few small matters here before I yield to my friend from Iowa.

First, I cannot thank my colleague from Connecticut enough. He has worked so hard as the former chairman of the HELP Committee and now as a very active participant in the HELP Committee, along with Chairman HARKIN. I cannot thank him enough. The Senator from Connecticut has worked on health care in such a constructive way. I deeply appreciate his efforts.

Before I give up the floor, I wish to pay my strongest compliments to my colleague from Iowa, Senator GRASSLEY. Senator GRASSLEY is one heck of a guy. He represents his State, in my judgment, very, very well. As I am sure the Presiding Officer knows—certainly my colleague from Connecticut knows—we have worked very closely together, Senator GRASSLEY and I, on a nonpartisan basis as much as we possibly can because we both think—and I know most people think—good legislation is legislation where you work together, not where you are fighting each other.

Senator GRASSLEY and I started out trying to get this bill put together on a bipartisan basis working together. As it turned out, we did not quite get there. But I know in the end he would very much like to find a way to vote for health care reform, as most Members of the Senate would.

I am an optimist. I think most of us in this body are optimists. I have not given up yet. Who knows how this is going to evolve? Who knows what the amendments are going to be? Who knows what the votes are going to be in the next several weeks or so? But I am looking for an opportunity where Senator GRASSLEY and other very constructive Senators will join us, all together, in a way, with a little give and take here, perhaps, to find a solution.

So I just want to end by saying how much I appreciate the Senator. He does a super job.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I thank the Senator from Montana for his kind remarks. He does describe the situation very well, particularly one where there was a very close working relationship during the summer and up until the middle of September, when people in this body felt we were not moving fast enough to get a product before the body, and so some of us were shoved to the side, not by Senator BAUCUS but by other people in this body.

I also compliment Senator DODD from this standpoint—that as I look at this 2,074-page bill we call health care reform, that as he described parts of this bill, I think you get a broad consensus that the things he talked about should be done. But that does not describe everything in this bill and it does not describe the opposition that comes to a certain part of this bill now, not only by Members of the body, but if you follow polls and town meetings around the country, you find a lot of the people are having second thoughts about the words ''health care reform.''

I would suggest to you, if you were in a coffee shop in any small town of the United States and they were talking about health care reform, and I came into that coffee meeting and I said: The bill before the U.S. Senate is going to raise premiums, it is going to raise taxes, it is going to take hundreds of billions of dollars out of Medicare, and it is not going to do anything about the inflation of health care, I will bet you that people at the end of that would say: Well, that doesn't sound like health care reform to me.

Even though Senator DODD describes a lot of things that are neither Democratic nor Republican nor even bipartisan, there is kind of a consensus that these things ought to be done. He describes it accurately. But, still, a lot of goals that were sought by those of us who were negotiating these things over a period of several months—that we ought to have it be revenue neutral—and on the 10-year budget window, it is revenue neutral. But, remember, that is 10 years of increased taxes and 6 years of program to make that happen. So you raise the question, if it was 10 years of expenditures and 10 years of income, would it be revenue neutral? Well, obviously not. And it does not do anything about health care inflation. Those are two goals that were sought over a long period of time. This 2,074-page bill does not do that.

I believe the people of the United States think our country has the best doctors and nurses in the world. But as Senator DODD pointed out, there is widespread agreement that the health care system in America does have problems. Costs are rising three times the rate of inflation. Americans are uninsured. Millions more fear losing their insurance in a weak economy and because of preexisting conditions. Doctors are ready to close their doors over high malpractice costs and low government reimbursement. So everybody says we need health care reform. Everybody agrees on that very much.

But, today, the Senate begins debate on a bill—2,074 pages—that would make a bad situation worse. It is unfortunate that early efforts to reach bipartisan solutions in Congress deteriorated into leadership-driven, partisan exercises.

The bills in Congress slide rapidly down the slippery slope to more and more government control of health care. They contain the biggest expansion of Medicaid since it was created 43 years ago. They impose an unprecedented Federal mandate for coverage, backed by enforcement authority of the Internal Revenue Service. They increase the size of government by $2.5 trillion when fully implemented. They give the Secretary of Health and

Human Services extraordinary powers to actually define benefits for every private health plan in America and to redefine those benefits annually. They create dozens of new Federal bureaucracies and programs to increase the scope of the Federal Government's role in health care. That is a lot of power over people's lives, and it is concentrated here in Washington, DC, in the Federal Government.

The excesses of the bill appear willfully ignorant of what is going on in the rest of the economy outside of health care. These excesses make the bill far worse than doing nothing.

At this point in our Nation's history, we are a nation facing very challenging economic times—some people would say the great recession, not quite the Great Depression; other people would say the worst recession we have had since 1982. What have we seen? We have seen the auto industry go into bankruptcy. We have seen banks shutter their doors.

I have a chart that is up. We call it the wall of debt chart. The Federal debt has increased by $1.4 trillion just since inauguration. This chart shows the growing amount of debt the Federal Government is taking on. The amount of increased debt added just since the inauguration is $11,500 per household. It now exceeds $12 trillion for the first time in history.

Within 5 years, the Obama administration's policies will more than double the amount of debt held by the public, and by 2019 it will more than triple the debt. That is not according to this Senator but according to the Congressional Budget Office and the White House Office of Management and Budget. Already, foreign holdings of U.S. Treasurys stands at nearly $3.5 trillion or 46 percent of the Federal debt held by the public. In other words, people outside of this country are holding 46 percent of our Federal debt.

At the beginning of this debate, one of the key promises of health care reform was—and I said this previously, but I will repeat it now—that it would bring down Federal health costs. This needs to be done before health spending sinks the Federal budget and saddles the taxpayer.

I have another chart, a health spending chart or, more accurately, a Federal health spending chart. As this chart illustrates, this bill bends the Federal spending curve further upward by $160 billion over the next decade. The red area of this chart, emphasizing the red area of the chart, shows net additional Federal health spending—again, not according to this Senator but according to the Congressional Budget Office.

Americans have rightly lost faith when, in the face of the current economic crisis—the ''great recession''—Congress thinks this $2.5 trillion restructuring of our health care system is a good idea.

The Reid bill also includes a government-run plan. A government-run plan would drive private insurers out of business and lead to a government takeover of the health care system. From rationing health care to infringing on doctor-patient relationships, a government-run system would guarantee U.S. taxpayers a staggering tax burden for generations to come.

The government cannot be a regulator, a funder, and a competitor at the same time without doing a great deal of damage to what the private sector has been doing for 60-some years. A government-run plan is not necessary for health care reform unless perchance the goal is to put in place the power of the Federal Government to drive down costs by—how? Not just driving them down but the consequences of that: rationing care and slashing payments to providers. These problems are bad enough, but much worse is that this bill—this bill—fails to solve the fundamental problems in health care. None of them take serious steps to reduce costs in health care.

The bills will cause health care premiums for scores of people to go up, not down. An analysis just released this very day by the Congressional Budget Office confirms our worst fears about the impact this bill will have on people's health insurance premiums. According to the Congressional Budget Office, the new benefit mandates and regulatory changes will actually increase costs of nongroup health insurance for individuals and families by 10 to 13 percent. That means millions of people who are expecting lower costs as a result of health care reform will end up paying more in the form of higher premiums. For large and small employers that have been struggling for years with skyrocketing health insurance premiums, the Congressional Budget Office concludes this bill will do little, if anything, to provide relief.

In fact, they cover their increased premiums they cause by spending even more on subsidies because of the increased premiums. So what happens? They do this by handing over close to $500 billion in hard-earned taxpayer dollars directly to health insurance companies. That sure doesn't sound as though this bill is actually reforming the market. The nonpartisan Congressional Budget Office analysis makes clear the Reid bill is not fixing the problem.

The Reid bill also imposes new fees and taxes that will be pushed directly to the consumer. These new fees and taxes will total about one-half trillion dollars over the next few years. On the front end, these fees and taxes will cause premium increases beginning next year when they go into effect, and those new fees increase premiums—for 4 years; they are there for 4 years—before most of the reforms take effect in 2014.

Then after forcing health premiums to go up, the legislation makes it mandatory to buy health insurance. Let's think about mandatory health insurance. The Federal Government is a government of limited powers under the 10th amendment. To my knowledge—and I think I know a lot about U.S. history—never in 225 years has the Federal Government said you had to buy anything. You don't have to buy—you buy what you want to buy in America, but not when this 2,054-page bill goes into effect. Then you will buy health insurance.

Somebody is going to throw at us: Well, the States make you buy car insurance, and probably most States do. My State of Iowa does. But under the 10th amendment, the State governments have a lot of power the Federal Government doesn't have.

The Reid bill also makes problematic changes to Medicare. It imposes higher premiums for prescription drug coverage on seniors and the disabled. The Reid bill creates a new independent Medicare board with broad authority to make further cuts in Medicare, and this bill makes that commission permanent. The damage this group of unelected people could do to Medicare is, in fact, unknown.

What is more alarming is that so many providers got exempted—they have political power, so they got exempted from the cuts this board would make—that it forces the cuts. Then what happens? They fall directly and disproportionately on seniors and the disabled.

Sooner or later, it has to be acknowledged that by making this board permanent, those savings are coming more and more—are going to bring more and more cuts to Medicare. That is a good example of the philosophical differences between the two sides in this body, and as the country divides itself more against this 2,054-page bill than for it, but still a large number of people in America support going in this direction. So those are philosophical differences between the two sides.

There are alternatives. Some of us want to reduce the overall cost of the legislation. We want to try to reduce the pervasive role of government, make it harder for undocumented workers to get benefits, allow alternatives to the individual mandate and harsh penalties, and add medical malpractice reforms. I bring a little bit of emphasis to medical malpractice reform because at my town meetings throughout this past year and particularly during the month of August people would say: Why don't you first try to save money in health care costs by taking on the lawyers and doing medical malpractice reform? But, instead, the prevailing view is to move millions of people from private coverage into public coverage and create new government programs that cover families making close to $90,000. Yet, even with all of these changes, after raising one-half trillion dollars in new taxes, cutting one-half trillion dollars in Medicare, imposing stiff new penalties for people who don't buy insurance, and increasing costs for those who do—after all of these changes, the Congressional

Budget Office says there are still 24 million people who will not have health insurance under the Reid bill.

I don't think this is what the American people had in mind when the President and the Congress promised to fix the health care system.

It is not too late for bipartisan legislation, so I have the hope that Senator BAUCUS just expressed before I spoke that builds on common ground to improve coverage, affordability, increased quality, and decreased costs. So here are some more alternatives. I have worked for years on bipartisan legislation that would transform Medicare from paying for volume of services provided to the quality of care delivered. There is also widespread support for stronger rules on insurance companies to make coverage more affordable and accessible, especially for small businesses and for people who aren't offered coverage by their employers, and for reforms to stop denials of coverage due to preexisting conditions. Tort reform would reduce abusive lawsuits that drive up costs and surely limit access to doctors. The nonpartisan Congressional Budget Office estimates that comprehensive medical liability reform would reduce Federal budget deficits by roughly $54 billion over the next 10 years. It would save even more when nonfederal health spending is taken into account. That would mean lower premiums for individuals and families.

So far the Democratic leaders in Congress have little interest in creating an environment where doctors don't have to engage in defensive medicine just to keep their practices open because somebody might sue them. The medical community should continue to make the case for reasonable reforms that will cut down on unnecessary medical tests that serve no purpose except to reduce malpractice premiums and to protect against frivolous lawsuits.

On several occasions, Republicans tried to take the legislative substance in a whole different direction. We tried to ensure the President's pledge not to tax middle-income families, seniors, and veterans was carried out. However, we were rebuffed at every step of the way. Republicans' efforts to provide consumers with a lower cost benefit option were consistently defeated. That means despite the promise, a lot of people are not actually going to be able to keep what they have as they were promised in the last Presidential campaign.

The Democratic leaders in Congress are advancing their extremist health care reform bills with a bare minimum of votes to do the job. I disagree with that approach. Health care is one-sixth of the economy. That is as large as the entire British economy. The legislation Congress is considering will affect every American at every level of health and at every stage of employment. When the debate began last year—in fact, it was just this month of November that I remember 8 or 10 of us from different committees met with a solemn pledge. We were going to work together in a bipartisan way to get this job done. We met again for the next 6 months several times, but it just didn't work out.

But when that debate began last year, interested legislators of both parties set benchmarks that were no-brainers:

Health care reform should lower the cost of premiums. It should reduce the deficit. It should bend the growth curve in health care the right way—downward. The Reid bill doesn't do any of these things.

It is not too late to start over. I guess Senator BAUCUS has put forth that invitation. I hope it materializes. If both sides can set aside some philosophical differences, and if the Democratic leaders are willing to refocus on the principles that brought us to the table months ago, I believe we can produce health care reform that improves the quality of life for Americans who are suffering under the current health care system and doesn't degrade the quality of life for everyone else.

But it is not the entirety of this 2,074-page bill. These issues can be addressed without upending the entire health care system, with the result of higher taxes, higher insurance premiums, and deficits and debt that will get in the way of opportunities that result from the ingenuity and productivity and industry of the American people.

I get back to that coffee shop meeting, where people are discussing health care reform. As I walk into that coffee meeting and I tell them that this 2,074-page bill increases taxes, increases premiums, takes 400 or more billion dollars out of Medicare, and it doesn't do anything about controlling costs, according to the Congressional Budget Office, that group again will say: That doesn't sound like health care reform to me.

As we start this debate this week, I urge my colleagues to listen to the American people. The Reid bill is in the wrong direction.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

MOTION TO COMMIT

Mr. MCCAIN. Madam President, I ask unanimous consent to send to the desk at this time a motion to commit with instructions.

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

The clerk will report the motion.

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 to report the same back to the Senate with changes that do not include the following:

(1) Medicare Advantage cuts totaling −$118.1 billion.

(2) Medicare Advantage payment changes totaling −$1.9 billion.

(3) Provider cuts totaling −$150.0 billion.

(4) The establishment of the Independent Medicare Advisory Board totaling −$23.4 billion.

(5) Reporting requirements for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs totaling −0.2 billion.

(6) Penalties to hospitals totaling −1.5 billion.

(7) The expansion of CMS spending totaling −1.3 billion

(8) A Medicare shared savings program totaling −4.9 billion.

(9) Hospital penalties totaling −7.1 billion.

(10) A revision to the Medicare Improvement Fund totaling −22.3 billion.

(11) Home health care cuts totaling −42.1 billion.

(12) Hospice payment changes totaling −0.1 billion.

(13) Medicare disproportionate share hospital payments changes totaling −20.6 billion.

(14) Cuts to advanced imaging services totaling −3.0 billion.

(15) A revision of the payment for power-driven wheelchairs totaling −0.8 billion.

(16) Cuts for certain medigap plans totaling −0.1 billion.

(17) A reduction in the part D premium subsidy for high-income beneficiaries totaling −10.7 billion.

(18) Outpatient prescription drug cuts in long-term care facilities totaling −5.7 billion.

(19) Changes to preventive services in Medicare totaling −0.7 billion.

(20) A limitation on the Medicare exception to the prohibition on certain physician referrals for hospitals totaling −0.7 billion.

(21) Comparative effectiveness research totaling −0.3 billion.

(22) The elimination of indexing for part B premiums totaling −25.0 billion.

And reflects the Sense of the Senate that any savings to the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) by reason of the provisions of, and amendments made by, sections 6401, 6405, 6407, and 6410 should be used to strengthen the Medicare program under title XVIII of such Act.

Mr. MCCAIN. Madam President, simply put, this motion to commit would be a requirement that we eliminate the one-half trillion dollars in Medicare cuts that are envisioned by this bill—one-half trillion dollars in cuts that are unspecified as to how, and one-half trillion dollars in cuts that would directly impact the health care of citizens in this country—Medicare Advantage cuts totaling $118 billion; an independent Medicare advisory board that would cost $23 billion; an expansion of Medicare hospital penalties totaling $7.1 billion; home health care cuts totaling $42.1 billion; and hospice—of all the things—payment changes. The list goes on and on.

All of these are cuts in the obligations we have assumed and that are the rightful benefits people have earned—particularly our senior citizens—across this Nation. This eliminates one-half trillion dollars in cuts to Medicare that are cuts that are unspecified.

I eagerly look forward to hearing from the authors of this legislation as to how they can possibly achieve one-half trillion dollars in cuts without impacting existing Medicare programs negatively and eventually lead to rationing of health care in this country.

That is what this motion is all about. This motion is to eliminate those unwarranted cuts. All of us know there are enormous savings in fraud, abuse, and waste that can be identified. No expert I know of believes that would come up to one-half trillion dollars. Hospitals are cut by $105 billion. Nursing homes are cut by $14.6 billion. Hospices are cut by $7.6 billion.

These are not attainable cuts, without eventually rationing health care in America and rationing health care for our senior citizens, who have earned these benefits, and we have guaranteed them these benefits.

For the life of me, how the AARP can support this 2,000-page legislation is beyond my imagination. Seniors all over America, including Arizona, including the 330,000 senior citizens in my State who are under the Medicare Advantage Program, which will be drastically cut by some $120 billion, are outraged. The more they find out about it, the more angry they are becoming.

Here we are, as my colleague from the great State of Iowa, a leader on health care, articulated, with a totally partisan measure before the Senate, in which no Member on this side of the aisle has been consulted in any way. I point out that, historically, there has never been a major reform implemented by the Congress of the United States unless it is bipartisan in nature, and I don't believe the American people want this 2,000-some-page monstrosity, which is full of all kinds of provisions that they are either unaware of, or even in the study of this legislation, many of us have also become unaware of. But fundamentally, the Bernie Madoff/Enron accounting that has been going on with this bill is dependent upon envisioning one-half trillion dollars in cuts that are not attainable. If they are attainable, it would mean a direct curtailment and reduction of the benefits we have promised the senior citizens of this country. That is not acceptable.

What this motion to commit does is send it back to the Finance Committee: Come back with another bill. Only this time, don't put the cost of it on the backs of senior citizens of this country. Don't do it. It was back last summer, 3 months before he was elected President, on a campaign stop not far from Washington, DC, now-President Obama vowed not only to reform health care but to do it in a new way. He said:

> I am going to have all the negotiations around a big table, televised on C–SPAN, so that people can see who is making arguments on behalf of their constituents and who are making arguments on behalf of the drug companies or the insurance companies.

Americans wanted to believe this would be true. Republicans offered to work with the majority on our ideas. But that was rejected. So what has happened? Business as usual. Let me read from a report of this past weekend about business as usual:

> The Associated Press has moved a story saying that health care lobbyists and other interests have made 575 visits to the White House between January and August. The report is based on records released by the White House on Wednesday.
>
> The timing of the release smells of a classic Washington tactic—dumping bad news on the getaway day before a long weekend. Clearly, the White House, which prides itself as being the most transparent administration in the history of the world, hopes this nugget gets lost over the four-day Thanksgiving weekend.

AP's Sharon Theimer:

> Top aides to President Barack Obama have met early and often with lobbyists, Democratic political strategists and other interests with a stake in the administration's national health care overhaul, White House visitors records obtained Wednesday by the Associated Press show.

All of my fellow citizens watching, I urge you to call the White House and say you want to have an appointment to meet with the President or members of the administration in the White House. Five-hundred-seventy-five special interests were able to get in. Why can't you? Give them a call. Tell them you want to meet with the members of the administration. That is what 575 lobbyists have been able to do. Give them a call.

Continuing to quote:

> The records show a broad cross-section of the people most heavily involved in the health care debate [except for average citizens] weighted heavily with those who want to overhaul the system.

It talks about who were among them.

> The list also includes George Halvorson, chairman and CEO of Kaiser Health Plans; Scott Serota, president and CEO of Blue Cross and Blue Shield Association; Kenneth Kies, a Washington lobbyist who represents Blue Cross/Blue Shield, among other clients; Billy Tauzin, head of PHARMA, the drug industry lobby; and Richard Umbdenstock, chief of the American Hospital Associations.
>
> Several lobbyists for powerful health care interests, including insurers, drug companies, and large employers also visited the White House complex, the records show.

Again, citizens, why don't you call the White House and ask for an appointment? The lobbyists and special interests—big donors—get it. They are not ambassadors. They are lobbying the White House on this issue.

Health care reform should have been about both sides sitting down together and fixing what is broken, reducing health care costs, while preserving the highest quality health care in the world.

Somewhere in the course of this debate, in the process of this legislation, we have lost sight of the fundamental problem with health care in America, and that is the cost of health care in America, not the quality. This legislation will destroy the quality and the availability, if the cuts envisioned in this legislation—this Enron accounting measure, where the first 4 years after this legislation—suppose this legislation were signed on the 1st of January by the President of the United States. Immediately benefits will begin being cut. Immediately taxes will go up. Guess what. None of the benefits will be given to any American citizen for 4 years. That is how you get deficit neutrality. That is how you get deficit neutrality.

If you started giving the benefits at the same time you raise the taxes, you have got about $1.3 trillion in deficit in a $2.5 trillion bill—a $2.5 trillion piece of legislation. Here we are with the highest deficits in history, with deficits and debt as far as the eye can see, with a stimulus package that has done so well that we now have 10.2 percent unemployment, and many predict it will go even higher. Wall Street is doing fine, and lobbyists are doing fine. Mr. Tauzin, the PhRMA lobbyist, is doing fine. I understand his salary is a couple million dollars a year, not to mention all the other perks. But the average citizen, including the 330,000 citizens of my State, who have the Medicare Advantage Program, are going to see it cut and cut over and over again—about $120 billion worth.

So what happened? The White House engaged in the tradition of handing out favors to special interests, including PhRMA, AARP, and AMA. Shame on AARP and shame on the AMA. We know there are many commonsense reforms that Americans want.

By the way, in this monstrosity, find me any significant, real medical malpractice reform. The threat of medical malpractice causes physicians to practice defensive medicine. The CBO estimates it would be roughly a savings of $54 billion over 10 years. That does not take into consideration the cost of defensive medicine that doctors have to practice because of fear of being sued.

I ask the distinguished chairman of the committee: Where is any meaningful medical malpractice reform in this 2,000-page bill? Where is it?

I had a townhall meeting the other day in Arizona, as I do quite frequently. There were a lot of doctors, nurses, and caregivers who came. I asked them: What do you do about medical malpractice reform? Every one of them said: We practice defensive medicine. We prescribe additional tests and procedures. We have to do it because we will find ourselves in court by the trial lawyers.

Do not underestimate, I say to my friends, the many special interests and their influence in this legislation, but do not underestimate the stunning success of the American Trial Lawyers Association that has made sure there is no provision in this bill that has to do with medical malpractice reform.

By the way, if there is an example, it is called the State of Texas. The State of Texas enacted meaningful and yet not draconian medical malpractice reform. Premiums have gone down. Cases have gone down. Doctors are flooding back into the State of Texas. It has worked.

We are going to hear from the other side that there may be demonstration projects, there may be this, there may be that. The demonstration project is the State of Texas. That is all we have to do. It has already been proven.

Instead of a reform which could save tens if not a couple hundred billion dollars, what are we going to do? We are going to cut hospitals by $505 billion, nursing homes by $14.6 billion, hospices by $7.6 billion, and the list goes on and on, up to one-half trillion dollars. My motion will send it back to the Finance Committee and tell them to remove these unnecessary, unneeded, unwanted, harmful cuts in the Medicare system, which will not allow us to fulfill our obligation to the senior citizens of this country.

Buried in this partisan legislation, as I mentioned, are 10 years of tax increases and Medicare cuts, a total over $1 trillion. Using CBO numbers, this stack of partisan legislation costs $2.5 trillion over its 10-year implementation.

Let me put this in different terms for you. Suppose you want to buy a house. You go and buy the house, but the terms of the contract of purchasing the house say you have to make payments on the house for the first 4 years and then after 4 years you can move in. That is why this is Bernie Madoff accounting. It is a sham. It is a sham. It is a sham to make people pay taxes and have their benefits cut for 4 years and then only after 4 years do the benefits kick in. That is the way, with this kind of accounting, they get to deficit neutral. It is crazy. It is crazy.

The increased taxes and Medicare cuts begin impacting Americans and our economy in 32 days, if this is passed. Let me repeat this. Starting in January 2010, just 1 month from now, the majority begins tax increases and Medicare cuts, starting in January, and incredibly delays implementation of this bill for 4 years. That is 1,460 days and 208 weeks of new taxes and Medicare cuts before implementation. That is playing games with the American people.

If they were not playing games by delaying implementation of the bill 4 years after the tax increases and Medicare cuts, we would not even be discussing this pile of legislation because it would be scored as adding over $1 trillion to our deficit.

If the other side wanted to be honest and reject the Madoff-Enron accounting, they would be talking about the first 10 years of real costs and the first 10 years of their tax increases and Medicare cuts.

The respected dean of the Washington press corps, David Broder, pointed this out just last week in his column in the Washington Post entitled ''A Budget-Buster in the Making.'' By the way, the majority leader then felt compelled to come down and trash one of the most respected columnists in America whom I don't need to take the time to defend; he can defend himself and so will many others who have great respect for David Broder.

David Broder's column said:

It's simply not true that America is ambivalent about everything when it comes to the Obama health plan.

The day after the Congressional Budget Office gave its qualified blessing to the version of health reform produced by Senate Majority Leader Harry Reid, a Quinnipiac University poll of a national cross section of voters reported its latest results.

. . . by a 16-point margin, the majority in this poll said they oppose the legislation moving through Congress.

Broder went on to say:

I have been writing for months that the acid test for this effort lies less in the publicized fight over the public option or the issue of abortion coverage than the plausibility of its claim to be fiscally responsible.

This is obviously turning out to be the case. While the CBO said that both the House-passed bill and the one Reid has drafted meet Obama's test by being budget-neutral, every expert I have talked to says that the public has it right. These bills, as they stand, are budget-busters.

Here, for example, is what Robert Bixby, the executive director of the Concord Coalition, a bipartisan group of budget watchdogs, told me: ''The Senate bill is better than the House version, but there's not much reform in this bill. As of now, it's basically a big entitlement expansion, plus tax increases.''

These are nonpartisan sources, but Republican budget experts such as former CBO director Douglas Holtz-Eakin amplify the point with specific examples and biting language. Holtz-Eakin cites a long list of Democratic-sponsored ''budget gimmicks'' that made it possible for the CBO to estimate that Reid's bill would reduce federal deficits by $130 billion by 2019.

Perhaps the biggest of these maneuvers was Reid's decision to postpone the start of subsidies to help the uninsured buy policies from mid-2013 to January 2014—long after taxes and fees levied by the bill would have begun.

Even with that change, there is plenty in the CBO report to suggest that the promised budget savings may not materialize. If you read deep enough, you will find that under the Senate bill, ''federal outlays for health care would increase during the 2010–2019 period''—not decline. The gross increase would be almost $1 trillion—$848 billion, to be exact, mainly to subsidize the uninsured. The net increase would be $160 billion.

But this depends on two big gambles. Will future Congresses actually impose the assumed $420 billion in cuts to Medicare, Medicaid and other federal programs? They never have.

Why don't we tell the truth to the American people and take these supposed cuts out of this bill? Tell them the truth about what it costs and tell them the truth that this is a dramatic expansion of entitlements, but at the same time those presently eligible, those senior citizens, such as the 330,000 who are under the Medicare Advantage Program in my home State of Arizona, will not see that program maintained. You cannot reach these kinds of savings, these kinds of reductions, these kinds of cuts without impacting existing programs. I know of no expert who says it will who is an objective observer. I believe Dr. COBURN, Dr. BARRASSO, and others in the medical profession will say the same thing. Every time Congress has enacted so-called cuts in Medicare or contemplated it, they have never taken place.

That doctor fix? We took care of that problem. We just took it out of the bill. But you know what we are going to do about the doctor fix. Every year we are going to delay it, delay it and delay it and it will never happen. That has been the history of the so-called doctor fix since its beginning.

And will this Congress enact the excise tax on high-premium insurance policies (the so-called Cadillac plans) in Reid's bill? Obama has never endorsed them, and House Democrats—reacting to union pressure—turned them down in favor of a surtax on millionaires' income.

The challenge to Congress—and to Obama—remains the same: Make the promised savings real, and don't pass along unfunded programs to our children and our grandchildren.

That means taking this legislation back, taking out these cuts in Medicare and programs that are vital to the citizens of this country and come back with a realistic—a realistic—piece of legislation that has malpractice reform, the ability to go across State lines to get the health insurance policy of your choice, rewards for wellness and fitness, expansion of health savings accounts, and medical malpractice reform.

There are many cost-saving measures we can enact to bring the cost of health care in America under control and preserve quality. Instead, we are doing the opposite.

If you are going to make these kinds of cuts—the $420 billion in cuts to Medicare and Medicaid and other Federal health programs—then you are going to impact the provision of health care in America.

Americans have been clear overspending has to stop, nor do the American people believe empowering Washington bureaucrats in a new Federal health care entitlement is health care reform. The other side disregards the message from the American people all across the country, and the bill does the opposite.

I wish to talk just for a minute about a provision in this bill that is very important; that is, the transfer of power, the massive transfer of power in this bill to the Secretary of Health and Human Services. This is a huge transfer. ''HHS would become federal giant under Senate plan'' by Susan Ferrechio:

A quick search of the Senate health bill will bring up ''secretary'' 2,500 times.

That's because Health and Human Services Secretary Kathleen Sebelius would be awarded unprecedented new powers under the proposal, including the authority to decide what medical care should be covered by insurers as well as the terms and conditions of coverage and who should receive it.

I wish to repeat that. In this bill, the Secretary has the ''authority to decide what medical care should be covered by insurers as well as the terms and conditions of coverage and who should receive it.''

We saw a little precursor of that the other day with, for example, recommendations concerning mammograms. A board recommended that women under 50 should not get routine

mammograms. Of course, the response was incredible and justified. Women all over America are now alive today because they had mammograms prior to the age of 50. The Secretary of Health and Human Services said that would not be carried out, et cetera. We are creating a situation where the Secretary of Health and Human Services and a board would decide that.

''The legislation lists 1,697 times where the Secretary of Health and Human Services is given the authority to create, determine or define things in the bill,'' said Devon Herrick, a health care expert at the National Center for Policy Analysis.

For instance, on Page 122 of this 2,079-page bill, the secretary is given the power to establish ''the basic per enrollee, per month cost, determined on average actuarial basis, for including coverage under a qualified health care plan.''

The HHS secretary would also have the power to decide where abortion is allowed under a government-run plan, which has drawn opposition from Republicans and some moderate Democrats.

And the bill even empowers the department to establish a Center for Medicare and Medicaid Innovation that would have the authority to make cost-saving cuts without having to get the approval of Congress first.

''It's a huge amount of power being shifted to HHS, and much of it is highly discretionary,'' said Edmund Haislmaier, an expert in health care policy and insurance markets at the Heritage Foundation, a conservative think tank.

Haislmaier said one of the greatest powers HHS would gain from the bill is the authority to regulate insurance. States currently hold this power, and under the Senate bill, the federal government would usurp it from them. This could lead to the federal government putting restrictions and changes in place that destabilize the private insurance market by forcing companies to lower premiums and other charges, he said.

''Health and Human Services doesn't have any experience with this,'' Haislmaier said. ''I'm looking at the potential for this whole thing to just blow up on people because they have no idea what they are doing. Who in the Federal Government regulates insurance today? Nobody.''

''The health care reform legislation would rely on the U.S. Preventive Services Task Force for recommendations as to what kind of screening and preventive care should be covered. Last week, the group, which operates under HHS, drew sharp criticism for advising that mammograms should begin at age 50, a decade later than the current standard.''

''Critics of the bill said this was an example of how the new bill could empower HHS to alter health care delivery, but Democrats argue they would rather have the government making these decisions.''

That is the key to it. They would rather have the government making these decisions. If you like the way the post office is run, you will love the way HHS runs health care in America.

I understand the amendment of the other side may address some of this, but under the Reid bill the Senate moved to consider, beginning in 32 days, the language from the bill on page 1,189 authorizes the Secretary to modify benefits under Medicare pursuant to task force recommendations. As I mentioned, how many women would have died if the coverage provisions guiding the new Federal plan under mammograms had been implemented? Then, on the following page, 1,190, the Secretary is authorized to deny payment for prevention services that the task force recommends against. So if this unelected panel changes the preventive recommendation for some other type of cancer, the Federal Government plan would not cover it. I don't think the American people want their health coverage decisions coming from a panel in Washington.

The Reid bill drives up costs and premiums. Just today the CBO released its assessment of what will happen to health insurance premiums under the new entitlement compared with premiums today. The CBO dealt a blow to claims the health care bill introduced by Senator REID will lower premiums when they released an analysis showing that premiums will go up significantly in the individual market. Premiums for individuals without employer-sponsored coverage would increase 10 to 13 percent or $2,100 per family in 2016. The Democrats' bill therefore requires individuals to purchase insurance that is more expensive than would be available under current law. For small businesses and employers, the bill largely preserves the status quo and does little if anything to lower the cost. In fact, CBO estimates that under the Reid bill the average family with employer-sponsored coverage will soon pay more than $20,000 per year for health insurance.

President Obama said the following during the campaign:

I have made a solemn pledge that I will sign a universal health care bill into law by the end of my first term as President that will cover every American and cut the cost of a typical family's premium by up to $2,500 a year.

Well, CBO's analysis shows that the President is breaking that pledge by both failing to achieve universal coverage and raising premiums, just as it contradicts an analysis by MIT economist John Gruber released by the White House this weekend claiming that individual premiums would go down. In fact, even with the generous assumptions made by CBO in a number of areas, premiums will either go up or remain unchanged.

From the CBO report just today, CBO says premiums in the individual market would be 10 percent to 13 percent higher in 2016 than under the current law. Average premiums would increase by $300 for an individual policy and by $2,100 for a family policy. The new benefit and coverage mandates actually drive up premiums by 27 to 30 percent, and this increase is offset by other factors, such as new administrative efficiencies.

CBO says that little more than half of enrollees in the individual market would receive a government subsidy. However, the bill before us would still require nearly 14 million Americans to purchase unsubsidized insurance that is more expensive than they have today.

President Obama has promised that seniors will not see a reduction in benefits. In fact, he said recently:

People currently signed up for Medicare Advantage are going to have Medicare and the same level of benefits.

How did he get there? How do you get there when you are cutting Medicare Advantage by $120 billion? There is no math—old or new—that gets you to no change in the benefits that they have under Medicare Advantage and yet cutting $120 billion. Traditional Medicare doesn't offer coordinated benefits that can improve the quality of care. Traditional Medicare doesn't have many of the aids or benefits for our seniors.

President Obama has also promised several times, ''If you like what you have, you can keep it.'' The American people took those words as a promise that if they had a health benefit they were happy with, they could keep it. I want to make sure we are helping the President keep his promise. I want to help him keep his promise by sending this bill back, taking out the cuts that are in it on Medicare, on the $105 billion cuts to hospitals, nursing homes by $14.6 billion, hospices cut by $7.6 billion, Medicare Advantage by $120 billion. I want to send it back to the Finance Committee and come back with a bill that the American people can believe in that will preserve the solemn obligations we have made to our senior citizens.

Medicare Advantage provides the only choice in the Medicare Program allowing an option for seniors who want additional benefits or a better option. Medicare Advantage is working for nearly 11 million seniors to give them a choice about their health care and better benefits. As I mentioned, 330,000 beneficiaries in my State of Arizona are in Medicare Advantage, and they will see benefit reductions or their plan disappear. Eighty-nine percent of seniors need and have some form of supplemental coverage on top of Medicare to provide protections against out-of-pocket costs or additional benefits. Many low-income Americans and minorities rely on Medicare Advantage as their supplemental coverage.

Some have claimed that cutting the ''extra payments'' to Medicare Advantage plans reduces insurance company profits. Under Federal law, that is simply not the case. The fact is, 75 percent of those ''extra payments'' go directly to better benefits for seniors under current law. The other 25 percent goes back to the Federal Government. Unfortunately, those extra benefits will be taken from seniors who are enrolled in Medicare Advantage.

This bill contains $120 billion in direct cuts to private Medicare plans. Common sense says you can't do that without affecting benefits. The Congressional Budget Office thinks so as well. CBO assumes the Reid bill will cut benefits by more than half, from an average of $98 in additional benefits to $41 a month.

I see one of my colleagues is waiting to speak, but I hope the American people will understand what we are trying to do. All we are trying to do is send this back to be reworked, to be fixed on a bipartisan basis, and not to force $400-some billion in cuts and benefits that we have promised the American people. We want to send it back and come out with a bipartisan approach. Sit down, for the first time, Republicans and Democrats, have the C–SPAN cameras rolling—the way the President promised he would a year ago last October.

Let's sit down together and figure out how we can fix this.

The best way to fix it is to preserve the quality of health care in America and bring down the cost, not to pass a 2,074-page monstrosity that is full of the measures that would impair the ability, particularly of our senior citizens, to keep the benefits they have earned and we have promised them.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. CASEY. Madam President, I rise to speak about health care, as we begin the debate in the Senate. I am grateful we are finally at this point where the Senate at long last will be debating our health care bill. It has been a long time in coming. Some of us have waited years, some have waited for decades to be at this point in our history.

On the Senate floor now is the Patient Protection and Affordable Care Act, and we are going to be discussing various aspects of that over the next couple of weeks.

I am reminded, as I rise today, of something Hubert Humphrey said a long time ago. He said the test of the government is how it treats those in the dawn of life—our children—those in the shadows of life—those who have challenges in their life, as we try to help them—and those in the twilight of life—older citizens across America. In large measure, we will be talking about each of those Americans in one way or another and a lot of other Americans as well. I rise to speak of our children but also to spend a couple of moments talking about older citizens, especially in light of some of the arguments made most recently on the Senate floor.

I will start with our older citizens. I come from the State of Pennsylvania where in our little State, with more than 12 million Pennsylvanians, we have almost 1 million Pennsylvanians over the age of 65. We have a very high number of Pennsylvanians on Medicare and also a lot of families who rely upon that kind of health care coverage, as we have for many generations. So when we speak of those in the twilight of life, we speak of many Americans who are covered by Medicare.

I want to make a couple of points about the bill that is on the floor now. First of all, with regard to older citizens, a couple of basic points on which I will provide a little more background. First of all, this bill, as it relates to Medicare, will protect Medicare's already guaranteed benefits. The bill also reduces premiums and copays for older citizens. It will ensure that older citizens can keep their own doctor or doctors with whom they have developed a relationship, on whom they have come to rely, and in whom they have confidence. So we want to make sure they can keep their own doctors.

The bill keeps Medicare from going bankrupt in 8 years by stopping waste, fraud, and abuse and by other provisions as well. The bill provides new preventive and wellness benefits—something we have talked about for every age group, but we are finally going to do something about it to give people better health care options.

The bill also, as it relates to older citizens, lowers prescription drug costs. We will talk more about that. We have had a lot of discussion over the last couple of years about the so-called doughnut hole. That is a very nice-sounding way of describing falling into a period of coverage, if you are an older citizen getting prescription drug coverage, where you have to pay the whole freight, so to speak. This bill provides relief for those who are in that so-called doughnut hole with regard to Medicare prescription drug coverage.

Finally, this bill keeps older citizens in their homes and limits those who would be compelled, if they didn't get additional help, to go into nursing homes. Some do. Some choose to do that. But we want to provide more opportunity for people to stay in their homes, if they can.

In terms of preserving Medicare without the changes made in this bill, Medicare is going broke in 8 years—not 18, not 80, but 8 years—if we do nothing. Older citizens will have trouble accessing their doctors if we don't take action. Older citizens will have trouble affording prescription drugs if we don't take action. Finally, without reform, cost sharing for older citizens will increase to completely unaffordable levels.

Next, we have to make sure older citizens across America have the opportunity to continue to receive guaranteed protection for hospital stays, access to doctors, home health care, nursing home, and prescription drug coverage. We have to make sure we extend the life of the Medicare trust fund beyond 2022. Without reform, we cannot extend the Medicare trust fund beyond 2022. Without reform, we do not have the opportunity to ensure that trust fund will be there for older citizens across America. Finally, health reform will not interfere with any medical decisions made by patients and their doctors.

Let me step back a moment and reflect upon what we are talking about with regard to Medicare: Protecting our seniors, protecting their benefits. It is interesting to note this whole debate started January of 2009, in a fully engaged way, when staffs of all relevant committees were working on this, month after month. Then it went into the summer, working on health care reform in the Health, Education, Labor, and Pensions Committee and the Finance Committee, improving bills, changing the bills. Now we have one bill that is the result of all that work. So this has been going on for months and months.

I keep hearing criticisms from my Republican colleagues on various aspects of the bill. There is nothing unusual about that. It is natural to have a decision and a debate. We are starting that today, at least on the floor. But we have been having a debate over many months. My point is that on the one hand you have the legislation that resulted from work by the two committees into one bill, so you have the Patients Protection and Affordable Care Act on the floor and you have had basically the ideas contained in that being discussed for many months. But what we have not seen, what I have been waiting for and have not seen, is a bill by the other side.

In other words, when we were working in June and July in the HELP Committee or when the Finance Committee was working all summer and into the fall, you would think that one of the results from that would be that Democrats had a point of view and they produced a bill; Republicans had a point of view. But they did not produce a bill. So you basically have a choice before the American people: the bill before us, which will change and which will be amended. I have some things I would want to change. But the answer cannot be let's go back to square one, where we were a year ago or 5 years ago or 10 years ago and just cancel this and try to start over. This is the result of many years of work, especially many months of work by people at the staff level and Senators across the board.

Unfortunately, the other side does not have a plan, so I can only conclude they want to stay with the status quo. They think where we are in health care is OK; that we should stay where we are, maybe tinker with it a little bit but not change much. I think that is unacceptable. Too many people I run into, in Pennsylvania especially, have said to us: Please provide some protections for me. We are talking about individuals who have health care. Provide some consumer protections. Make sure the Medicare trust fund will always be there. Help me with this doughnut hole problem. This is the problem too many seniors run into when they cannot pay for prescription drugs at a certain point in the delivery of that benefit.

I do not think the response of doing nothing or staying where we are is acceptable. That is one of the reasons why we have to make sure we focus on changes or debates about this bill, not going back to where we were in January or where we were 5 years ago and basically doing nothing year after year about health care and saying it is OK to stay where we are.

We have a long way to go. But I think it is also important to point out this is not just a debate between Republicans and Democrats. We have had groups, across the board, that are neutral arbiters that weigh in on public policy but are not representing a Democratic point of view or a Republican point of view. The AARP said on November 20 of this year:

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?

So says the AARP, just a couple of weeks ago—not even a couple of weeks ago, 10 days ago. The AARP also said on November 18, 2 days earlier:

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

That is the AARP weighing in on not a concept, not a theory but the bill in front of us.

The American Medical Association, on that same day, November 20, 2009:

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

I could go on from there, but we have ample evidence that there is strong support for the ways this bill will strengthen Medicare.

I wish to move to the second topic I was going to cover today and that is the other end of Hubert Humphrey's test of government, what we do and what the test is of our Government as it relates to those in the dawn of life. I spoke of older citizens a moment ago. At the dawn of our life are children.

It has been a topic and a focus of mine since the very beginning of this debate, which for me began last spring when I was working in the Health, Education, Labor, and Pensions Committee before our work this summer on the bill. The Patient Protection and Affordable Care Act, which is the bill before us today, deals with many aspects of our health care system. One of them is how we take care of our children. I have come back to this issue over and over. I have had just a basic test for this legislation. It is very simple. It is four words: No child worse off, especially and importantly, children who are low income and are particularly vulnerable, therefore, and children with special needs. So ''no child worse off'' should be the foundation of what we do in this bill for our children.

That is particularly true for those who are vulnerable, as I said before; they are vulnerable or children with special needs. That is the foundation of what we should be doing, the foundation for a guiding philosophy. The way I look at this, every child in America, no matter who they are, no matter what circumstance, every child in America is born with a light inside them. For some, that light is boundless because of their circumstance, because of their ability, because of advantages they have. Their potential is unlimited and that light burns very brightly without any help from anyone else. That is some children.

Then there are other children who have a light inside them and are deserving of our care and protection and advocacy. We have a lot of people around here who get besieged by lobbyists for different points of view, but very rarely do we have the same kind of lobbying power, the same kind of power in our system to stand for children. So we have to do that if an interest group will not. There are plenty who have advocated strongly for our children, but they don't get enough attention in my judgment.

There are some children who are born with a light inside them that does not burn very brightly because of their own circumstances or limitations or because of particular vulnerabilities that they have. They are the ones for whom we have to fight the hardest. They are the ones we have to stand up to the special interests for because they cannot do it for themselves. They don't have a voice sometimes in this debate unless the Senate stands up for them.

I believe no matter what the light is inside a child, no matter what the limit or whether it is unlimited potential, we have to make sure that potential is reached, the full potential—not most of it, not some of it, the full potential of every child, the full burning of that light inside them.

There are two programs that work well to do that. They are Medicaid and the Children's Health Insurance Program. Thank goodness both these programs came along: Medicaid, some 40 years ago, and Children's Health Insurance Program less than the last 15 years.

We have the opportunity to listen to people who come up to us on the street or who send us an e-mail or who send us a letter. It just so happens one of my constituents in Pennsylvania sent us a note the other day, literally 2 days ago, November 28. I will not give away her identity, but I will give you a general sense of what her challenge is.

She wrote to us talking about her two children who are covered by the Children's Health Insurance Program in Pennsylvania. By the way, Pennsylvania is one of the first States that put into place this program, almost 20 years ago, back in 1992–1993.

She wrote and said she was concerned that the House, in their bill, had made some changes that would adversely impact her situation. She said:

We qualify for free Children's Health Insurance Program benefits in Pennsylvania but my husband's income is greater than the 150 percent of the Federal poverty level which means our children wouldn't qualify for the coverage under the House's proposed plan.

Then she says:

This has us terrified.

She goes on to talk about what she and her husband are trying to do to make ends meet. She says:

Our water bills will increase and we are nervously awaiting the annual increase in heating.

I will not go through the whole letter, but suffice it to say we have a program in place now, the Children's Health Insurance Program, that works for families right now. Now we are engaged in a great debate on health care on the floor of the Senate and we deal with programs such as the Children's Health Insurance Program. What we have to make sure about is that we do nothing in this process to injure or harm or set limits on what we can do with a program that we know works.

This is a program which is good for a child, to make sure he or she reaches the full potential of that light inside them. This is good for his or her family. Imagine the peace of mind that a mother or father has in the course of the day, whether they are going off to work or whether they are home, to know their child has health care. Yet we have some families, some parents, terrified even with the coverage they have, worried that coverage will not remain in effect for their children. So we have to make sure that rule is followed: No child worse off in America. We want to fix what is broken and build upon what works.

I wish to make sure, as we go through this, we have a sense of what the difference is between these benefits and what can happen down the road. One of the things that will have an adverse impact on our health care system, generally, but in particular on a program such as the Children's Health Insurance Program, will be the skyrocketing cost of coverage. The share of household incomes spent on premiums is climbing. The New America Foundation reports that in 2008, household income spent—on the side, ''percent of median household income spent on health care''—is 26.3 percent. That is far too high as of 2008.

With no action, if we stay where we are, go down the same road we are on, the status quo, don't change anything, let's start over and keep scratching our head about this, here is what is going to happen by 2016, 7 years away. That median household income dedicated to health care will skyrocket to 45 percent nationally.

Unfortunately, in Pennsylvania, it goes up over 51 percent instead of 45 percent, so that is the ''do nothing'' path right now. Do nothing, and we can guarantee that those costs are going to keep going up and up.

I said before we know the Children's Health Insurance Program works. By the way, when that bill passed and when it was reauthorized, we had help from both sides of the aisle—sometimes not enough help but we have had help supporting that program. We know this program works because we can see it from the results achieved by our children because of this program.

Let's compare this to some other challenges in the economy. The national poverty rate. In 2007, a little

more than 37 million Americans were in poverty, 12.5 percent of the population. In 2008, it was up to 13 percent. So the poverty rate went up from 2007 to 2008. The child poverty rate went from 18 percent to 19 percent, almost 1 million more kids in 1 year falling into poverty because of changes in the economy. People without health insurance, 2007 versus 2008, that has gone up. It may only be 15.3 to 15.4, but look at the overall number, from 45.7 to 46.3. Everything is going up. We would expect that, as tragic as that is, when times are bad. The national poverty rate is up, the child poverty rate up, and the uninsured rate is up.

What has not gone up between 2007 and 2008 is the number of uninsured children: 8.1 million in 2007 were covered; 7.3 million kids covered in 2008. That is good news, that the number of uninsured children is actually going down from roughly 8 to 7 million. That is good news. Why is that happening? It is not magic. If we didn't have a Children's Health Insurance Program, that number would be going up just as the other numbers. Why is the uninsured number for children going down? One basic reason—and we could point to maybe a few others—is because we have a program called the Children's Health Insurance Program which works and which, fortunately, we reauthorized a couple of months ago. Thank goodness we did that, or more and more children would fall into poverty. We are on a path now to go from the number of children who are insured, to get that number that is now in the double figure millions, to get that to 14 million children, to have that uninsured number keep going down and cover more and more children. In a couple of years, we will have the opportunity to say that in America, we have 14 million kids covered. What we have to do is make sure we have a successful program that works for the child, for their family, and for our society. Because guess what. We are going to have a better economy because of the Children's Health Insurance Program. If we invest in a child early, they get health care, and they will learn better. When they learn better, they will be doing better in school and have a better job and have a higher skill level. This whole debate about children's health insurance isn't just a nice thing to do; it is how we compete around the world in a tough economy. It is how we build a skilled workforce in a tough economy. It is how we build strong families.

This isn't just some nice program. This has real results for our economy, for gross national product growth, economic growth, for a skilled workforce. Fill in the blank. You could add 10 themes to that in terms of the impact of the legislation. But you have to be careful. In the midst of this health care reform debate, we have to make sure we don't do what some have urged which is to take the Children's Health Insurance Program, this program that we know works, and drop that into the health insurance exchange that will be created as a result of this bill. The exchange is a good idea to cover a lot of people. It just happens to be a bad idea when it comes to merging or putting the Children's Health Insurance Program in there. It needs to remain a stand-alone program.

One of the reasons why we can say we are at that point where it is a stand-alone program still is because during the debate in the Finance Committee, Senator ROCKEFELLER of West Virginia ensured that we kept the Children's Health Insurance Program out of the exchange and that the program would continue until 2019. Unfortunately, the House doesn't have the same provisions, and we want to make sure we do that by the end of the debate.

I filed an amendment today to make sure that children are protected by health care reform, so we can truly say that no child is worse off as a result of our health care reform bill. In a nutshell, this amendment will strengthen and safeguard health care for children in CHIP from now until 2019 and beyond with whatever changes the future of health care reform brings.

I will provide a couple of highlights. It continues funding through 2019. It ensures that children have access to the essential care they need. It streamlines and simplifies enrollment. The amendment also provides financial incentives for States to increase enrollment of eligible but uninsured children and calls for a study of children under the Children's Health Insurance Program compared to coverage of children under the so-called insurance exchange.

These are just some highlights of my amendment. I will be talking more about it.

I conclude with this thought. I know Senator BAUCUS was here a moment ago, chairman of the Finance Committee, who has worked very hard on this bill, this program, the Children's Health Insurance Program, and on the health care reform bill overall to protect our kids. I return to this letter I got 2 days ago from a mother, in essence commending the benefits of this program, that this program gives her peace of mind. What we have to do is make sure we keep the Children's Health Insurance Program intact and, if anything, strengthened over time so this mother doesn't have to worry again, so she doesn't have to be ''terrified'' of changes that will adversely impact her two children, especially in the midst of a bad economy but even if it were not.

I thank the Chair and yield the floor.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from Wyoming.

Mr. ENZI. Madam President, I thank the Senator from Pennsylvania for his comments. I certainly hope no one who is listening thinks that anybody wants to make any child worse off. That is a basic premise, and I appreciate his pointing out the way the House makes some children potentially worse off.

I want to constrain my comments to the Medicare amendment because I think that is one of the key parts of this whole bill. The Senator from Pennsylvania mentioned that there wasn't a Republican bill. Actually, there are four Republican bills, and there is one bipartisan bill out there that meets all of the goals the President put out. When we were going through the HELP Committee amendment process, we put one of those out, and it was voted down with one vote. We said: That didn't work very well. There were a lot of good ideas in there. They ought to have to consider every one of those.

We have been putting our ideas out one at a time so that hopefully the other side will glean something out of the amendment that will be worthwhile to be a part of the bill. All the good ideas couldn't be on one side of the aisle.

We began the day with kind of a stunt which, of course, was to have the leader propose a unanimous consent. He proposed that the Social Security money ought to stay with Social Security. I don't think there was any problem with that. But then he proposed that CLASS Act money ought to stay with the CLASS Act. That is a fund that isn't even actuarially sound to begin with. It is just a piece of the bill that is already in existence around here. He left out what he should have put in that unanimous consent request. He should have said Medicare money should be reserved for Medicare. That would have relaxed a lot of seniors. But it would have been untrue and impossible to pass this bill if that were the UC, because Medicare money is going to expansion of new programs outside of Medicare. That is what is upsetting seniors. And it ought to.

Medicare, as everybody has said, is going broke. That is a government option that is going broke. Well, never mind. But Medicare is going broke. We all agree on that. So why would we take $464 billion out of Medicare to use on other programs and then recognize that Medicare is going broke and throw in a special commission that will come to us once a year and suggest cuts to Medicare? That is not a bad idea, but some side deals have been made in this whole thing that keep that from being a very realistic option either. The hospitals can't be cut any more. The doctors, we are going to have to fix that, and that is where some of the phony accounting comes in.

The pharmaceuticals, the little deal they made for the doughnut hole, that will provide extra help to seniors through the doughnut hole, but it has to be on brand name products. We know that generics are a lot less expensive and a lot of seniors switch to generics, especially when they get to the doughnut hole and have to make decisions on their own and they want to save a few dollars. But that will not be a possibility under this bill because of the deal that was made with the

pharmaceuticals. They are going to pay their percentage on brand name products only. Why would they do that? If they can get you to use brand name products through the doughnut hole, when the government starts paying again, you will still use the brand name.

One of the ideas with health care is to get a little skin in the game with everybody so people are making good choices on health care. How much of a good choice are you going to make if you don't have to make a choice and you can keep on doing what you have been doing, whether it is the best choice for you, whether it is even what the doctor agrees with, and whether it is a whole lot more expensive for the government to keep Medicare going?

I rise to support the McCain motion to commit this bill and eliminate its Medicare cuts. Senator REID's bill cuts $464 billion from the Medicare Program. These cuts will eliminate benefits for Medicare patients. They will make it harder for them to see doctors and other providers and will threaten the survival of hospitals, nursing homes, and home health agencies. Don't take my word for it. The administration's own chief actuary recently reviewed the House bill with its similar levels of Medicare payment cuts and reached the same conclusion I just said.

Richard Foster, chief actuary at the Centers for Medicare and Medicaid Services, CMS, wrote that if these cuts were to take effect, many providers ''could find it difficult to remain profitable and might end their participation in the program.'' He also noted that this could jeopardize Medicare beneficiaries' access to care. I have heard similar messages from doctors, home health aides, and nursing home owners back in Wyoming. They are all concerned about the one-half trillion dollars in Medicare cuts and what it will do to their ability to treat Medicare patients.

I have heard from folks at the Baggs Senior Center, the Star Valley Senior Citizens, the Southwest Sublette County Pioneers Senior Citizen Center, and from other Wyoming nursing homes about how the $15 billion in Medicare cuts to nursing home payments will devastate their ability to provide care for seniors in Wyoming. Many of these nursing homes are small businesses. They struggle to make payroll every month and deal with an ever increasing burden of government regulations. We have never cut those back. They tell me how their Medicare payment rates have already been reduced and how the additional cuts in the bill could force them to close their doors.

Connie Jenkins, executive director of the Star Valley Senior Center, recently wrote to me about the important role nursing homes play in rural towns in Wyoming. She noted that ''in a rural state such as ours, closure of nursing homes would mean families travelling farther to visit [their] loved ones and in some cases loss of access altogether.''

In rural States—and we are about as rural as you can get; we have the least population in the Nation, and we have a lot of land mass—there is a lot of distance between towns. If the nursing home in your town closes down, it is a long way to the next nursing home. The Reid bill would also cut $135 billion in Medicare payments to hospitals. In a State such as Wyoming, with an older population, between 40 to 50 percent of our hospital revenue comes from Medicare. Medicare already pays a fraction of what private insurers pay, and the cuts in this bill will undermine those hospitals' ability to continue to operate. I have heard from several Wyoming hospital executives that because of the payment cuts in this bill, they are going to need to ask their people to work fewer hours and take pay cuts.

They also said they may need to lay some folks off and to find ways to scale back the services they offer to their patients. They do not want to compromise the care they provide, but the payment cuts in this bill will not leave them a choice.

The Reid bill also cuts nearly $8 billion in payments to hospice care. Hospice care helps to relieve the suffering of people who are dying from diseases such as cancer. These are terminal patients, terminal patients who, of course, are not going to be cured. But the hospice is intended to help manage the pain and other symptoms of the patients with the terminal illness, and working with the families, much on a volunteer basis.

According to National Hospice and Palliative Care Organization, the cuts in the Reid bill, combined with prior regulatory cuts, would reduce Medicare payments to hospice providers by 14.3 percent through 2019. According to a June 2008 report from the Medicare Payment Advisory Commission, hospices already operate with narrow profit margins that average just 3.4 percent.

Smaller nonprofits and hospices in rural areas such as Wyoming already operate with negative profit margins. Many depend on charitable fundraising to keep their doors open and to enable them to keep treating patients. Yet the Reid bill would further cut their Medicare payments by $8 billion. This will force many hospices to close, which will threaten dying seniors' access to that type of care.

The Reid bill also cuts more than $40 billion in Medicare payments to home health agencies. According to the analysis done by one industry association, this level of cuts could put nearly 70 percent of all home health agencies at risk of having to close their doors. I want to say that again. The $40 billion in Medicare cuts to home health agencies, according to an analysis done by one industry association, could put nearly 70 percent of all home health agencies at risk of having to close their doors.

There are a lot of people who are out of nursing homes because they are getting home health care. If we eliminate home health care, we drive up the cost of care. If the Senate passes this bill, it will mean that Medicare patients may not be able to get the skilled nursing care, the physical and speech therapy, and the assistance that home health aides provide with many daily activities, such as dressing, bathing, helping patients live more fully with a disability.

The Medicare cuts in the Reid bill are not limited to slashing payments to hospitals and other providers. The bill also cuts $120 billion from the 11 million seniors on Medicare Advantage. These cuts make a mockery out of President Obama's promise that if you like what you have, you can keep it. As a result of these cuts, millions of Medicare beneficiaries will lose the benefits currently provided by Medicare Advantage plans.

Supporters of Senator REID's bill have tried to gloss over the impact these Medicare Advantage cuts will make, arguing they will only result in a loss of ''extra benefits.'' For the seniors who have come to rely on Medicare Advantage plans to provide things such as flu shots, eyeglasses, hearing aids, and protections against catastrophic costs, these are not extra benefits but items and services they depend on.

We all agree Medicare needs to be strengthened and reformed. Its financing is unsustainable. The Hospital Insurance Trust Fund, which pays for hospital services, will be insolvent in 2017. The physician payment formula, which calls for Medicare payments to doctors to be cut by more than 40 percent over the next 10 years, is fundamentally broken. We know that. We even had a vote on that in this Chamber. We said it had to be paid for.

Let's see, $464 billion coming out of Medicare. Medicare is what is being affected by the doctors' payments. Why wouldn't we use some of that? But it is a lot of money. It is a lot of money, but it is not as much money as we are taking out of Medicare.

Unfortunately, the Reid bill does nothing to fix these problems. Instead, it cuts one-half trillion dollars from Medicare to create a brandnew entitlement program for the uninsured. This approach fails to address the real problem facing Medicare; and that is the physician formula. Instead, it uses the same gimmick that Congress has repeatedly used to fix this problem and provides a temporary fix in 2010, which will actually lead to steeper cuts in subsequent years.

Physicians have grown increasingly frustrated by Congress's repeated failure to replace the current payment formula. We kind of like to keep them hanging on a year at a time. I think it is a little bit of a hostage situation, but that is the way Washington works. It should not be that way. We should redo the formula. If we do not address this problem soon, many more physicians are going to decide it is not

worth it to continue to treat Medicare patients.

The Congressional Budget Office has estimated that truly fixing the physician payment formula could cost upwards of $250 billion, yet the Reid bill does not address this problem.

Spiraling costs associated with medical liability lawsuits directly increase Medicare costs. These costs are calculated directly into payment formulas for providers such as physicians. In addition, physicians and hospitals order billions of dollars in extra tests and procedures to protect themselves from the threat of potential lawsuits.

We know that enacting commonsense medical liability reforms directly reduces the liability insurance premiums doctors pay. We have seen the results in States such as Texas, where physicians liability insurance premiums have decreased every year since the State-enacted reforms, with average liability rates dropping a total of 27 percent.

The Reid bill does nothing to address the problems of medical liability. Instead of including reforms that would help reduce Medicare costs and extend the solvency of the program, the only thing the Reid bill does is include a meaningless sense-of-the-Senate resolution on liability reform. That will not pay the bills.

We owe it to the 43 million people who depend on Medicare to reject the arbitrary cuts in the Reid bill. We need to come up with better solutions that will not endanger their ability to see a doctor or to get care at a hospital or a nursing home. Yes, if we do not pay the doctors, the doctors will not take them because in Medicaid they already will not take 40 percent of the patients; and in Medicare it is 20 percent already. A lot of people are being asked, when they call a doctor, if they are a Medicare patient. It is my contention if you cannot see a doctor, you do not have any kind of insurance at all. We do not take care of that problem, so we do need to come up with a better solution that will not endanger their ability to see a doctor or to get care at a hospital or a nursing home or to have home health care.

I believe we can do better. If the Senate passes this motion to commit, we can develop bipartisan reforms that will eliminate the unsustainable payment cuts and address the underlying problems facing the Medicare Program.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I am not in favor of doing nothing. The previous Democratic speaker, Senator CASEY, said if we do nothing, costs will go up. I think the fact is, if you look at CBO's analysis, it says costs will go up even more if this bill, this 2,074-page bill, passes. So I want to spend some time because there has been some obfuscation on what this Congressional Budget Office letter to Senator BAYH means.

This morning, the nonpartisan Congressional Budget Office sent a letter to Senator BAYH providing a very detailed analysis of what health insurance premiums will look like as a result of this 2,074-page bill. I have the letter from the Congressional Budget Office right here, if anybody wants to read it in detail.

Like many of us, Senator BAYH wants to know if the Reid bill is addressing our constituents' No. 1 priority: costs. I think if you were to have a Saturday morning coffee club meeting in almost any of the small towns of America, and they were discussing health care reform—and emphasis upon the word ''reform''—and I walked into that meeting, and if I told them under this 2,074-page Reid bill that costs were not going to be brought under control, taxes were going to go up, premiums were going to go up, and we were taking $400 billion out of Medicare to set up a new health care program, they would probably unanimously respond: Well, that does not sound like health care reform to me.

A lot of Senators are concerned about costs because that is what we are hearing from the grassroots of America. Everyone, from the dean of Harvard's Medical School to even the New York Times, has said this bill does not sufficiently address the rising cost of health care. But before today, we were still all anxiously waiting to hear what the Congressional Budget Office has now said about that issue of rising costs. Well, today, CBO has spoken loudly and clearly. The Reid bill not only fails to bring down costs, it will actually raise costs for millions of Americans. I think that bears repeating. The Reid bill will make health insurance more expensive. Families will end up paying 10 to 13 percent more as a result of this 2,074-page bill.

Some proponents of the bill are trying to spin this, what they consider unfortunate news, and tell the American people that taxpayer-funded subsidies will actually offset these cost increases. In fact, tonight some Members have already been saying that this CBO analysis shows costs will come down.

But I want to make it very clear CBO says that is not the case. Well, this may be true; if you take $500 billion of taxpayers' hard-earned money and give it out in subsidies directly to insurance companies, sure, some people may end up paying less for health insurance. But this argument fails to recognize two big underlying problems.

First, most Americans will not qualify for any subsidies. They will end up paying higher premiums. In fact, 160 million Americans who stay in employer-based plans will not see any help. In fact, despite all the rhetoric about how employers cannot afford the status quo, CBO says this bill does little, if anything, to lower costs for employers. Maybe that is why the National Federation of Independent Businesses, the U.S. Chamber of Commerce, and a host of other business groups, oppose this 2,074-page bill.

The nonpartisan Congressional Budget Office goes on to say that 14 million people who cannot get coverage through an employer will not get any help either, but they will see a 10- to 13-percent increase in premiums. And, of course, an intrusive new insurance mandate will be enforced by the IRS if you do not do what has never been done in the 225-year history of America. Never has the Federal Government said any American had to buy anything. Now you have to buy insurance. If you do not buy it, pay the IRS more money. Some people are going to say: Well, you have to buy car insurance. But under the tenth amendment, the State governments have any powers that are not prohibited by the Federal Constitution to them.

So families who would have paid $13,100 under current law will actually pay more than $15,000 as a direct result of this 2,074-page bill. And people in employer-based coverage will be paying more than $20,000 a year for health insurance in 2016.

The second big problem is this: Health insurance premiums are still more expensive in the Reid bill than they would be under current law. The government is cutting Medicare and raising taxes to offset the increases. So instead of addressing the underlying issue of cost, as was promised, this bill enacts policies that drive up costs by close to 30 percent, and then hands over close to $500 billion in hard-earned taxpayer dollars directly to health insurance companies to offset the increases.

Well, you might not believe the spin. In fact, you better not believe the spin because the nonpartisan Congressional Budget Office has confirmed it. This bill fails to drive down the cost of health insurance premiums. It simply drives up prices with a bunch of arbitrary regulatory reforms, very cutely shifting the cost on to the American people in the form of higher taxes and massive Medicare cuts. So, once again, don't take my word for it. Read what the nonpartisan Congressional Budget Office says. They have confirmed what we have been hearing for months: The Democratic leadership bill means higher costs for millions of Americans.

I yield the floor.

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

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

MORNING BUSINESS

Mr. DURBIN. Madam President, I ask unanimous consent that 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.

ADDITIONAL STATEMENTS

TRIBUTE TO PAT VEZINA

● Mr. BEGICH. Madam President, today I wish to recognize a milestone for my constituent Pat Vezina. On Friday, December 4, 2009, Pat will mark the 50th anniversary of her arrival in the State of Alaska. Alaska became a State in January 1959 and Pat made it her home less than a year later, one of thousands of people who have built our State over the last half century.

Pat was born in Wallsend, Northumberland, England, on June 4, 1931, to Clement and Constance Boothroyd. She grew up in Jesmond, Northumberland, and was evacuated for a short time during World War II before returning home to live with her parents for the duration of the war. After attending nursing school in Leeds, England, she emigrated to Canada and then to Alaska

Pat worked as a registered nurse in the labor and delivery department at Providence Hospital, one of Alaska's finest institutions. She began her Alaska nursing career at ''Old Providence'' hospital where hundreds of new Alaskans, including me, were born. After marrying and having two children of her own, she returned to nursing at ''New Providence'' where she worked for 30 years before her retirement in 1996.

Pat has an abiding love for the beauty of Alaska. She enjoys walking on the beaches of Homer, buying summer flowers for her garden in the greenhouses of the Matanuska Valley, picking berries at Sheep Mountain Lodge, and an afternoon with a friend at Summit Lake Lodge. She is loved by her children Karen and John and by the close friends she has made over the last 50 years.

Madam President and colleagues, please join me in honoring and recognizing Pat Vezina on the 50th anniversary of her arrival in Alaska.●

RECOGNIZING THE 169TH FIGHTER WING

● Mr. DEMINT. Madam President, Senator GRAHAM joins me today to congratulate the men and women of the 169th Fighter Wing stationed at McEntire Joint National Guard Base, SC, for their outstanding service in defending our Nation and for their great achievements at the 2009 Falcon Air Meet.

It has been 8 years since the attacks of 9/11 and the record of continuous operations for the 169th is an inspiration to us all. Shortly after the attacks, McEntire personnel deployed to Southwest Asia, directly participating in combat operations in support of Operation ENDURING FREEDOM, pounding al-Qaida and Taliban insurgents. Later, the 169th FW mobilized and deployed as part of what became Operation IRAQI FREEDOM. The Swamp Foxes flew more than 400 combat missions, performing the Suppression of Enemy Air Defenses mission and flying numerous precision bombing missions over Iraq.

However, when the 169th isn't defending freedom, they are winning awards and bringing home trophies. We are especially proud of the 169th's accomplishments at the 2009 Falcon Air Meet, a multinational F–16 competition. The Swamp Foxes represented the United States against other Nation's fighter crews. They finished first in four of five competition categories, earning the Large Force Employment Trophy, Scramble Launch and Intercept Competition, Weapons Load Competition, Top Overall Maintenance Award, and was recognized with the Top Overall Competition Award. These are impressive achievements that bring great credit upon the 169th.

On behalf of the people of the State of South Carolina and our great country, Senator GRAHAM and I want to salute the outstanding work of the 169th.

We are amazed by their stories, and humbled by the immense burdens they have shouldered. Their dedication, and their families' sacrifices are an inspiration, and our country owes them a debt of gratitude for their patriotic service.●

REMEMBERING MALCOM SHERMAN

● Ms. MIKULSKI. Madam President, I wish to pay to tribute the life and legacy of Malcolm Sherman.

Malcolm Sherman was part of that extraordinary generation that fought for America during World War II, and then fought for what America stands for during the rest of his life.

He joined the Marines after the Japanese attack on Pearl Harbor and served during the Guadalcanal campaign. When he returned home, he built a family with his beloved wife Mimi, and he built a career in real estate.

He truly lived his life according to the Jewish principle of ''tikkun olam''—the repair of the world through the pursuit of social justice. He worked for peace and civil rights throughout his life. He also was a leader in the effort to ending segregation and discrimination in housing. Perhaps his greatest legacies are his children and grandchildren, who live by his principles of service.

I ask that an obituary of Mr. Sherman written by Frederick Rasmussen of the Baltimore Sun be printed in the RECORD.

The information follows.

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

[From the Baltimore Sun, Nov. 21, 2009]

MALCOLM SHERMAN: FORMER ROUSE CO. EXECUTIVE BATTLED BLOCKBUSTING IN BALTIMORE NEIGHBORHOODS IN THE 1950S AND 1960S

(By Frederick N. Rasmussen)

Malcolm ''Mal'' Sherman, a former Rouse Co. executive and real estate agent who battled blockbusting and worked tirelessly for integrated neighborhoods during the 1950s and 1960s, died Thursday of pneumonia at the Broadmead retirement community in Cockeysville. He was 87.

Mr. Sherman was born in Philadelphia and spent his early years there. After the death of his father in 1927, he was sent abroad to a boarding school in Lausanne, Switzerland, where he lived until returning to New York City in 1932.

After graduating from Horace Mann School in New York City, Mr. Sherman attended the University of North Carolina at Chapel Hill.

He dropped out of college and enlisted in the Marine Corps two days after the Japanese attack on Pearl Harbor.

Mr. Sherman was wounded while serving as a master sergeant during the Guadalcanal campaign and was honorably discharged at war's end.

He was a founder of the United Nations Veterans League, which worked for world peace.

After the war, Mr. Sherman and his wife, the former Miriam ''Mimi'' Heller, whom he married in 1943, moved to San Francisco, where he was a salesman for Paul Masson Wines.

In 1949, Mr. Sherman moved to Baltimore to be closer to his wife's family. He earned his real estate license and established Mal Sherman Inc. Realtors. His staff consisted of 18 men and 18 women, at a time when there were few women in the business.

''I always had an interest in houses and land,'' Mr. Sherman said in a 1999 interview with the Maryland Realtor. ''I thought I could help people make a decision. I wanted to help families find a better quality of life. It was a way for me to combine business and social work all in one.''

In the early days, Mr. Sherman confronted anti-Semitism and segregated neighborhoods.

''As a Jewish real estate broker, I was not allowed to show property east of Falls Road,'' he recalled in the interview.

In 1953, when Mr. Sherman tried to stabilize a neighborhood that was undergoing blockbusting, he appealed to white residents to stay.

They rebuffed his plea and refused to do business with him because of his integrationist views.

Even after the Supreme Court's Brown v. Board of Education decision in 1954 that declared ''separate but equal'' unconstitutional, discrimination in real estate continued.

In 1960, Mr. Sherman decided it was time to hire African-American real estate agents and brought Lee Martin, a Morgan State graduate, into his company.

While working for Baltimore Neighborhoods Inc. in the early 1960s, Mr. Sherman began to push fair-housing issues and in a news conference said he would sell to anyone ''regardless of race, creed, or color.''

When baseball great Frank Robinson came to Baltimore to play for the Orioles in 1966, he instructed Mr. Sherman to find a home for him and his family in a white neighborhood.

''He didn't want to be segregated,'' Mr. Sherman recalled in an interview. After persuading the white neighbors to accept Mr. Robinson, Mr. Sherman was still attacked by a local builder for ''breaking the block.''

President John F. Kennedy appointed him to the Equal Opportunity for Housing in America Committee.

Mrs. Sherman, who died in 2005, joined her husband in his quest for open housing and civil rights.

''All that black people wanted was the right to buy or rent anyplace, regardless of race, creed or color, and once given that

right, they didn't necessarily inundate and run to the neighborhoods that they had been barred from,'' Mr. Sherman told The Sun in 2001.

He was later joined by other local brokers such as Russell T. Baker and Bill Wilson in the push for fair-housing laws that finally became a reality in 1968 when Congress passed legislation, but his crusade took a toll on his firm.

''Because he felt so strongly about these issues, it eventually put him out of business. It was a terrible thing to have happened,'' said Sandy Marenberg, president of MEI Real Estate in Baltimore.

''Mal held to his views all the way until the end of his life. He was a real hero and mentor in the Baltimore real estate community,'' Mr. Marenberg said.

In 1967, Mr. Sherman was named residential land sales director for the Rouse Co., and three years later was promoted to director of sales and land marketing in Columbia.

Mr. Sherman was named Rouse Co. vice president in 1971 with responsibilities for all residential land sales and helped steer Columbia toward racial diversity.

When he went to work for the Rouse Co., Mr. Sherman found a boon companion in Jim Rouse, the company founder, who shared his views.

''We were combating a trend, and Jim was frightened. He didn't want it [Columbia] to come out like the city,'' Mr. Sherman recalled in a 2000 interview in The Sun. ''He wanted all of the people mixed all over the place; that was the social goal.''

''He was a charismatic man always trying to help someone. He discriminated against no one,'' said James Holechek, a retired Baltimore public relations executive.

''It was a personal testimony when he was sought out and hired by Jim Rouse. To me, Mal Sherman was always Mr. Real Estate in Maryland,'' he said.

A liberal Democrat and an anti-war activist, Mr. Sherman found himself on the Nixon White House's enemies list after founding Businessmen Against the Vietnam War.

That's ''great news'' he told The Sun in 1973. ''It's the best thing I have to tell my son about myself. I feel better about this than any kind of honor that could come to me,'' he said.

After leaving the Rouse Co. in the early 1970s, Mr. Sherman went to work for Phipps Land Co. and later Ackerman & Co., a real estate firm based in Atlanta. He returned from Atlanta in 1981 when he was appointed Baltimore-Washington area regional vice president for the firm.

Mr. Sherman continued working as a real estate consultant after leaving Ackerman. He retired in 2001.

''He was arguably the wisest, most caring adviser and thinker in the Baltimore real estate world,'' said Martin L. Millspaugh Jr., who was the first chief executive of Charles Center-Inner Harbor Management Inc.

''His life made a difference over many years, in ways that will become even more apparent as time goes by,'' Mr. Millspaugh said.

He was a former president of the Real Estate Board of Greater Baltimore and in 1999 was awarded the Maryland Real Estate Board Life Achievement Award. Recently, he was honored for his civil rights work by the National Association of Realtors.

A former resident of the Colonnade in Homewood, Mr. Sherman was a member of the Baltimore Hebrew Congregation.

Services will be held at 1 p.m. Sunday at Sol Levinson and Bros., 8900 Reisterstown Road, Pikesville.

Surviving are two daughters, Wendy R. Sherman of Bethesda and Andrea Sherman of Dobbs Ferry, N.Y.; and two grandchildren. His son, Douglas Sherman, died in 1981.●

REMEMBERING ROYAL J. ''BUD'' WOOD

● Mr. THUNE. Madam President, today I mourn the loss of Royal J. ''Bud'' Wood, of Warner SD. Bud passed away on November 19, 2009, at the age of 87.

Born and raised in Warner, Bud will be remembered as a man who committed his life to his family and community. Bud celebrated his life with his wife Dorothy, his 4 children, 12 grandchildren, and 6 great-grandchildren. His passion for his faith, family, and friends was unwavering as he spent much of his time at church and family activities.

Although Bud was extremely dedicated to his family, he will also be remembered for his service to the State of South Dakota. I got to know Bud when his wife Dorothy managed Senator James Abdnor's office in Aberdeen. Elected to the South Dakota House of Representatives in 1966, Bud was one of the longest serving representatives, working for the people of South Dakota for 26 years. While a member of the State legislature, he served in many different capacities including: assistant majority leader, speaker pro tempore, speaker of the house, along with vicechairman of the Legislative Research Council and chairman of the Local Government Study Commission and Local Government Standing Committee. Bud also served on the Presidential Task Force for both President Ronald Reagan and President George H.W. Bush.

Beyond his political career, Bud was a talented auctioneer at Hub City Livestock Auction for 25 years. He was on the board of directors for the South Dakota Wheat Growers, the Warner Elevator Board, and at one time a church council member at St. John's Lutheran Church in Warner.

Bud was a man who was always willing and determined to help out his neighbor. A mentor, confidant, and friend, he selflessly impacted his community in a positive way.

Today I wish to celebrate the life of an extraordinary public servant and leader. As we mourn the loss of this great South Dakotan, I extend my thoughts, prayers and best wishes to Bud's family, friends, and loved ones.●

TRIBUTE TO THOMAS KURT JAROS

● Mr. THUNE. Madam President, today I recognize Thomas Kurt Jaros, an intern in my Washington, DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Kurt is a graduate of Downers Grove South High School in Downers Grove, IL. Currently he is attending the Biola University, where he is majoring in philosophy and political science. He is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Kurt for all of the fine work he has done and wish him continued success in the years to come.●

TRIBUTE TO DENNIS D'AQUILA

● Mr. THUNE. Madam President, today I recognize Dennis D'Aquila, an intern in my Washington, DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Dennis is a graduate of Wantagh High School in Wantagh, NY. Currently he is attending the Catholic University of America, where he is majoring in politics. He is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Dennis for all of the fine work he has done and wish him continued success in the years to come.●

TRIBUTE TO DYLAN KESSLER

● Mr. THUNE. Madam President, today I recognize Dylan Thomas Kessler, an intern in my Washington, DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Dylan is a graduate of Roncalli High School in Aberdeen, SD. Currently he is attending the Hillsdale College, where he is majoring in English. He is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Dylan for all of the fine work he has done and wish him continued success in the years to come.●

TRIBUTE TO BRITTNI PALKE

● Mr. THUNE. Madam President, today I recognize Brittni Jo Palke, an intern in my Washington, DC, office, for all of the hard work she has done for me, my staff, and the State of South Dakota over the past several months.

Brittni is a graduate of MACCRAY in Clara City, MN. Currently she is attending the Southeastern University, where she is majoring in journalism. She is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Brittni for all of the fine work she has done and wish her continued success in the years to come.●

TRIBUTE TO ALELI PARDO

● Mr. THUNE. Madam President, today I recognize Aleli Marie Pardo, an intern in my Washington, DC, office, for all of the hard work she has done for me, my staff, and the State of South Dakota over the past several months.

Aleli is a graduate of Carrollton School of the Sacred Heart in Miami,

FL. Currently she is attending the George Washington University, where she is majoring in political science. She is a hard worker who has been dedicated to getting the most out of her internship experience.

I would like to extend my sincere thanks and appreciation to Aleli for all of the fine work she has done and wish her continued success in the years to come.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

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 Mrs. GILLIBRAND:

S. 2817. A bill to amend part D of title V of the Elementary and Secondary Education Act of 1965 to provide grants to schools for the development of asthma management plans and the purchase of asthma inhalers and spacers for emergency use, as necessary; to the Committee on Health, Education, Labor, and Pensions.

By Mr. LEMIEUX:

S. 2818. A bill to amend the Energy Conservation and Production Act to improve weatherization for low-income persons, and for other purposes; to the Committee on Energy and Natural Resources.

By Mrs. FEINSTEIN:

S. 2819. A bill to amend the Poultry Products Inspection Act, the Federal Meat Inspection Act, and the Federal Food, Drug, and Cosmetic Act to require processors of food products to certify to the applicable Secretary that the processed food products are not adulterated; to the Committee on Agriculture, Nutrition, and Forestry.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. BENNETT (for himself and Mr. HATCH):

S. Res. 361. A resolution commending Real Salt Lake for winning the 2009 Major League Soccer Cup; to the Committee on the Judiciary.

By Mr. SHELBY (for himself, Mr. VITTER, Mr. COCHRAN, Mr. CORNYN, Mrs. HUTCHISON, Mr. ISAKSON, Mrs. SHAHEEN, and Mr. WICKER):

S. Res. 362. A resolution expressing the sense of the Senate that the Secretary of the Treasury should direct the United States Executive Directors to the International Monetary Fund and the World Bank to use the voice and vote of the United States to oppose making any loans to the Government of Antigua and Barbuda until that Government cooperates with the United States and compensates the victims of the Stanford Financial Group fraud; to the Committee on Foreign Relations.

By Mr. VOINOVICH (for himself and Mr. BROWN):

S. Res. 363. A resolution honoring the life and service of breast cancer advocate, Stefanie Spielman; to the Committee on the Judiciary.

By Mrs. SHAHEEN (for herself and Mr. DURBIN):

S. Res. 364. A resolution supporting the observance of National Diabetes Month; considered and agreed to.

ADDITIONAL COSPONSORS

S. 254

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

S. 332

At the request of Mrs. FEINSTEIN, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 354

At the request of Mr. WEBB, the name of the Senator from Massachusetts (Mr. KIRK) was added as a cosponsor of S. 354, a bill to provide that 4 of the 12 weeks of parental leave made available to a Federal employee shall be paid leave, and for other purposes.

S. 436

At the request of Mr. CORNYN, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 436, a bill to amend title 18, United States Code, to protect youth from exploitation by adults using the Internet, and for other purposes.

S. 456

At the request of Mr. DODD, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 456, a bill to direct the Secretary of Health and Human Services, in consultation with the Secretary of Education, to develop guidelines to be used on a voluntary basis to develop plans to manage the risk of food allergy and anaphylaxis in schools and early childhood education programs, to establish school-based food allergy management grants, and for other purposes.

S. 461

At the request of Mrs. LINCOLN, the names of the Senator from New Hampshire (Mrs. SHAHEEN) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 461, a bill to amend the Internal Revenue Code of 1986 to extend and modify the railroad track maintenance credit.

S. 510

At the request of Mr. DURBIN, the names of the Senator from Iowa (Mr. HARKIN) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 510, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the safety of the food supply.

S. 619

At the request of Mrs. FEINSTEIN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 678

At the request of Mr. LEAHY, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S. 678, a bill to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and for other purposes.

S. 781

At the request of Mr. ROBERTS, the name of the Senator from Delaware (Mr. CARPER) was added as a cosponsor of S. 781, a bill to amend the Internal Revenue Code of 1986 to provide for collegiate housing and infrastructure grants.

S. 795

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

S. 823

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

S. 870

At the request of Mrs. LINCOLN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 870, a bill to amend the Internal Revenue Code of 1986 to expand the credit for renewable electricity production to include electricity produced from biomass for onsite use and to modify the credit period for certain facilities producing electricity from open-loop biomass.

S. 987

At the request of Mr. DURBIN, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 987, a bill to protect girls in developing countries through the prevention of child marriage, and for other purposes.

S. 1008

At the request of Mr. THUNE, his name and the name of the Senator

from Oregon (Mr. WYDEN) were added as cosponsors of S. 1008, a bill to amend title 10, United States Code, to limit requirements of separation pay, special separation benefits, and voluntary separation incentive from members of the Armed Forces subsequently receiving retired or retainer pay.

S. 1067

At the request of Mr. FEINGOLD, the names of the Senator from Minnesota (Ms. KLOBUCHAR) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1217

At the request of Ms. STABENOW, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1217, a bill to amend title XIX of the Social Security Act to improve and protect rehabilitative services and case management services provided under Medicaid to improve the health and welfare of the nation's most vulnerable seniors and children.

S. 1317

At the request of Mr. LAUTENBERG, the names of the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Michigan (Mr. LEVIN), the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from New York (Mrs. GILLIBRAND) were added as cosponsors of S. 1317, a bill to increase public safety by permitting the Attorney General to deny the transfer of firearms or the issuance of firearms and explosives licenses to known or suspected dangerous terrorists.

S. 1353

At the request of Mr. LEAHY, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 1353, a bill to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits.

S. 1458

At the request of Ms. LANDRIEU, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1458, a bill to encourage the development and implementation of a comprehensive, global strategy for the preservation and reunification of families and the provision of permanent parental care for orphans.

S. 1535

At the request of Mrs. FEINSTEIN, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1535, a bill to amend the Fish and Wildlife Act of 1956 to establish additional prohibitions on shooting wildlife from aircraft, and for other purposes.

S. 1756

At the request of Mr. HARKIN, the names of the Senator from Washington (Mrs. MURRAY) and the Senator from Illinois (Mr. BURRIS) were added as cosponsors of S. 1756, a bill to amend the Age Discrimination in Employment Act of 1967 to clarify the appropriate standard of proof.

S. 1799

At the request of Mr. DODD, the names of the Senator from Missouri (Mrs. MCCASKILL) and the Senator from Minnesota (Mr. FRANKEN) were added as cosponsors of S. 1799, a bill to amend the Truth in Lending Act, to establish fair and transparent practices related to the marketing and provision of overdraft coverage programs at depository institutions, and for other purposes.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1927

At the request of Mr. DODD, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1927, a bill to establish a moratorium on credit card interest rate increases, and for other purposes.

S. 2097

At the request of Mr. THUNE, the name of the Senator from Wyoming (Mr. BARRASSO) 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. 2740

At the request of Mrs. MURRAY, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 2740, a bill to establish a comprehensive literacy program.

S. 2757

At the request of Mr. MENENDEZ, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 2757, a bill to authorize the adjustment of status for immediate family members of persons who served honorably in the Armed Forces of the United States during the Afghanistan and Iraq conflicts and for other purposes.

S. 2779

At the request of Ms. KLOBUCHAR, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 2779, a bill to promote Department of the Interior efforts to provide a scientific basis for the management of sediment and nutrient loss in the Upper Mississippi River Basin, and for other purposes.

S. 2781

At the request of Ms. MIKULSKI, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2787

At the request of Ms. COLLINS, her name was added as a cosponsor of S. 2787, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. CON. RES. 39

At the request of Mr. MENENDEZ, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution expressing the sense of the Congress that stable and affordable housing is an essential component of an effective strategy for the prevention, treatment, and care of human immunodeficiency virus, and that the United States should make a commitment to providing adequate funding for the development of housing as a response to the acquired immunodeficiency syndrome pandemic.

S. RES. 71

At the request of Mr. WYDEN, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. Res. 71, a resolution condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

S. RES. 337

At the request of Mr. BYRD, the names of the Senator from Washington (Mrs. MURRAY), the Senator from Pennsylvania (Mr. SPECTER), the Senator from Wyoming (Mr. BARRASSO), the Senator from Ohio (Mr. BROWN), the Senator from Montana (Mr. BAUCUS) and the Senator from Montana (Mr. TESTER) were added as cosponsors of S. Res. 337, a resolution designating December 6, 2009, as ''National Miners Day''.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. FEINSTEIN:

S. 2819. A bill to amend the Poultry Products Inspection Act, the Federal Meat Inspection Act, and the Federal Food, Drug, and Cosmetic Act to require processors of food products to certify to the applicable Secretary that the processed food products are not adulterated; to the Committee on Agriculture, Nutrition, and Forestry.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce the Processed Food Safety Act. When enacted, this bill will make one very important principle clear: It is the producer's responsibility to produce safe food, it is not the consumer's responsibility to make their food safe.

This legislation gives food producers and anyone else who modifies our food

two options: they can take an additional ''kill-step'' to eliminate all verifiable traces of pathogens within each ingredient they have added to the product, or they can certify to the Secretary of Agriculture that each of the ingredients used to make our food contains no verifiable traces of pathogens.

One would think that this is common sense. Wouldn't any company producing or modifying our food take the time, and the care, to make sure that their product was safe for us to eat?

Unfortunately not. Today, more than 100 years after the publishing of Upton Sinclair's ''The Jungle,'' much of our food is still produced by companies that put their profits over the health of their customers.

On any given week I can open up the newspaper and find another heartbreaking story about the serious health effects of food-borne illnesses from tainted products. Anyone who visits the Web sites of the USDA or the FDA can see that recalls are not a rare occurrence.

In the last month the USDA has recalled: Roast beef in Iowa due to the presence of undeclared allergens; canned soup in Pennsylvania due to the undeclared presence of egg in the product; beef tongues in Nebraska and Wisconsin because of improperly removed tonsils, which, when consumed, increase the risk of contracting Mad Cow Disease; and hundreds of thousands of pounds of ground beef in California, New York, and Massachusetts due to the presence of E. coli 0157—the deadliest strain of this common pathogen.

The FDA this month has recalled: Dove ice cream bars in 19 States including California for the undeclared presence of peanuts, a potentially deadly allergen; Jelly Belly Jelly Beans were also recalled due to the presence of peanuts and peanut butter in their product; apple and carrot pouches in California that may contain a spore that can lead to botulism; vegetarian spring rolls in Maine, which were found to have meat products. The uninspected meat could have contained any number of food-borne pathogens; pre-made sandwiches in North Carolina due to concerns about the presence of Listeria. These bacteria can cause serious illness, pregnancy complications and even death; salted herring in New York because of the possible presence of the spore that can lead to botulism; and dried plums in Texas, found to contain traces of lead.

Simply put, the state of our food supply is alarming. And without serious reform and leadership from this Congress, things will not get any better. That is why today I am introducing the Processed Food Safety Act.

As I said, this bill will require companies that process any kind of food, from ground beef to frozen pot pies, to test their finished products and their ingredients to make sure that they are safe to eat and pathogen free.

I mentioned ground beef and frozen pot pies, two very different items, because both of these seemingly unrelated products have been the subject of two recent exposés in the New York Times.

On October 4, 2009, writer Michael Moss highlighted the disturbing realities in the ground beef industry, at each step in the process. He found slaughterhouses don't take time to properly remove intestines and fecal matter which then contaminate meat with E. coli. These slaughterhouses then sell to grinders who agree not to test their product for contaminants. Meat grinders purchase scraps from a variety of slaughterhouses across the country and across the globe. They then combine their scraps in a way that makes it virtually impossible to trace back their ingredients for public health purposes. Federal agencies offer regulations and guidance, but they fail to compel the industry to comply with their safety standards.

Each individual oversight is a problem, but together, they represent a clear, systematic failure of the overall food safety system.

This story makes it abundantly clear that the companies producing our ground beef spend more time worrying about how to avoid testing for pathogens than they spend trying to make their products safe.

The New York Times ran another story on May 15 that highlights serious concerns about frozen chicken pot pies.

The newspaper discovered that ConAgra, a frozen food giant which produced and sold over 100 million pot pies last year, decided to make consumers responsible for killing pathogens in their products instead of taking the responsibility themselves.

As consumers, we expect that producers of these frozen meals have properly cleaned and washed their ingredients before repackaging them for sale. We expect that these frozen entrees are ready for consumption—just ''heat and eat,'' the popular advertising motto tells us.

However, as this story points out, companies have actually tried to shift this burden to the consumer by requiring very specific, often burdensome cooking instructions which require the use of a meat thermometer to test the temperature of a product in several different places.

What is even more shocking is that the authors found that it was virtually impossible to meet the cooking specifications put on the box by ConAgra.

On the outside of the box, the cooking instructions state that the product must reach 160 degrees in several places as tested by a meat thermometer, before the product is safe to eat.

However the New York Times found that even after using a higher power microwave than recommended by ConAgra, and cooking the product for an additional 1 minute and 30 seconds, 30 percent longer than recommended, parts of the pot pie did not reach the temperature recommended by ConAgra to kill pathogens within their product.

When asked if a sample of their product that was cooked above and beyond their recommendations was safe to eat even though it did not reach the recommended temperature, the company conceded that it was not safe for human consumption.

Other frozen food products from Nestle, Swanson, and Hungry-Man were also tested to see if their cooking directions were clear, simple, and adequate. Not surprisingly, the New York Times found that their tests on these products yielded similar results.

Increasingly, food producers are using consumer cooking instructions as a method to deflect responsibility for the safety of their product. These companies effectively said that it was up to the consumer to kill potentially deadly doses of E. coli and Salmonella in their frozen meals.

Under current law, food producers are allowed to get away with this. That is why I am introducing the Processed Food Safety Act.

The bill will dean up the food industry by: amending the Poultry Products Inspection Act, the Federal Meat Inspection Act and the Federal Food, Drug and Cosmetic Act to prohibit the sale of any processed poultry, meat or FDA-regulated food that has not undergone a pathogen reduction treatment or been certified to be virtually pathogen free; doing away with loopholes in current laws that allow for producers to add coloring, synthetic flavorings and spices to their products without informing the consumer; and banning the sale of food that has not undergone these rigorous inspections and safety procedures.

The Processed Food Safety Enhancement Act will force companies to produce safe foods. And, it will let consumers know that their health is more important than the financial interests of the food industry.

Some may argue that this bill will be too expensive, because the inspections and tests required by this bill may raise the cost of food. I believe that these concerns are short-sighted.

The Centers for Disease Control and Prevention estimate that food-borne illnesses sicken up to 76 million people, cause 325,000 hospital visits, and cause more than 5,000 deaths each year. The CDC estimates that these illnesses annually cost American taxpayers up to $6 billion.

By another metric, the USDA food-borne illness cost calculator estimates that Salmonella cost the United States $2.6 billion in 2008, and E. coli 0157 cost $478 million.

By implementing more rigorous safety standards for our food, the Processed Food Safety Act may actually result in a substantial cost savings to the average American consumer.

But that misses the point. This bill, and this problem cannot be measured in dollars and cents. Food-borne illnesses kill up to 5,000 people every year. In this day and age, this is simply unacceptable. We cannot let this go on.

Food producers must be held responsible for the safety of their products. In the early 1900s Congress acted forcefully to prohibit the most egregious violations in food production. Today, 104 years after ''The Jungle'' was published, it is time for Congress to again take up this important fight.

The Processed Food Safety Act puts the responsibility for food safety back where it belongs. This legislation protects consumers and keeps our food safe.

I am proud to introduce this legislation, and I urge my colleagues to support this important, commonsense bill.

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

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

S. 2819

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Processed Food Safety Act of 2009''.

SEC. 2. POULTRY SAFETY.

(a) DEFINITION OF MISBRANDED.—Section 4(h) of the Poultry Products Inspection Act (21 U.S.C. 453(h)) is amended—

(1) in paragraph (5)—

(A) by inserting ''(A)'' after ''(5)'';

(B) by striking ''showing (A) the name'' and inserting the following: ''showing—

''(i) the name'';

(C) by striking ''distributor; and (B) an accurate'' and inserting the following: ''distributor;

''(ii) subject to subparagraph (B), an accurate''; and

(D) by striking ''count: *Provided,* That under clause (B) of this subparagraph (5), reasonable'' and inserting the following: ''count; and

''(iii) an accurate description of each cut of poultry or poultry product contained in the package or other container; and

''(B) except that under subparagraph (A)(ii), reasonable'';

(2) in paragraph (7)(B), by striking ''(other than spices, flavoring, and coloring)''; and

(3) in paragraph (9)(B), by striking ''; except that spices, flavorings, and colorings may, when authorized by the Secretary, be designated as spices, flavorings, and colorings without naming each''.

(b) PROHIBITED ACTS.—Section 9 of the Poultry Products Inspection Act (21 U.S.C. 458) is amended—

(1) in paragraph (5), by striking the period at the end and adding ''or''; and

(2) by adding at the end the following:

''(6) sell, transport, offer for sale or transportation, or receive for transportation, in commerce, any poultry or poultry product that is capable of use as human food, unless the person (including any slaughterer, poultry products broker, renderer, processor, reprocessor, retail food store, or official establishment) affirmatively certifies to the Secretary that—

''(A) each ingredient in the poultry or poultry product that was added, modified, or otherwise handled by the person has undergone a pathogen reduction treatment in accordance with requirements of the Secretary that will reduce the presence of pathogens of public health concern and other harmful food borne contaminants; or

''(B) the person has tested and certified that each ingredient in the poultry or poultry product that was added, modified, or otherwise handled by the person contains no verifiable traces of pathogens.''.

(c) PHASE-IN PERIOD.—Paragraph (6) of section 9 of the Poultry Products Inspection Act (as added by subsection (b)(2)) shall not apply until the date that is 18 months after the date of enactment of this Act.

SEC. 3. MEAT SAFETY.

(a) DEFINITION OF MISBRANDED.—Section 1(n) of the Federal Meat Inspection Act (21 U.S.C. 601(n)) is amended—

(1) in paragraph (5)—

(A) by inserting ''(A)'' after ''(5)'';

(B) by striking ''showing (A) the name'' and inserting the following: ''showing—

''(i) the name'';

(C) by striking ''distributor; and (B) an accurate'' and inserting the following: ''distributor;

''(ii) subject to subparagraph (B), an accurate''; and

(D) by striking ''count: *Provided,* That under clause (B) of this subparagraph (5), reasonable'' and inserting the following: ''count; and

''(iii) an accurate description of each cut of meat or meat food product contained in the package or other container; and

''(B) except that under subparagraph (A)(ii), reasonable'';

(2) in paragraph (7)(B), by striking ''(other than spices, flavoring, and coloring)''; and

(3) in paragraph (9)(B), by striking ''; except that spices, flavorings, and colorings may, when authorized by the Secretary, be designated as spices, flavorings, and colorings without naming each''.

(b) PROHIBITED ACTS.—Section 10 of the Federal Meat Inspection Act (21 U.S.C. 610) is amended—

(1) by striking ''**SEC. 10.** No person'' and inserting the following:

''SEC. 10. PROHIBITED ACTS.

''No person'';

(2) in subsection (c)—

(A) by striking ''in commerce (1) any'' and inserting the following: ''in commerce—

''(A) any'';

(B) by striking ''which (A) are capable of use as human food and (B) are'' and inserting the following: ''that—

''(i) are capable of use as human food; and

''(ii) are''; and

(C) by striking ''(2) any'' and inserting the following:

''(B) any'';

(3) by redesignating subsections (a) through (d) as paragraphs (1) through (4), respectively, and indenting appropriately;

(4) in paragraph (4) (as so redesignated), by striking the period at the end and inserting ''; or''; and

(5) by adding at the end the following:

''(5) sell, transport, offer for sale or transportation, or receive for transportation, in commerce, any meat or meat food product that is capable of use as human food, unless the person, firm, or corporation (including any slaughterer, meat broker, renderer, processor, reprocessor, retail food store, or official establishment) affirmatively certifies to the Secretary that—

''(A) each ingredient in the meat or meat food product that was added, modified, or otherwise handled by the person, firm, or corporation has undergone a pathogen reduction treatment in accordance with requirements of the Secretary that will reduce the presence of pathogens of public health concern and other harmful food borne contaminants; or

''(B) the person, firm, or corporation has tested and certified that each ingredient in the meat or meat food product that was added, modified, or otherwise handled by the person, firm, or corporation contains no verifiable traces of pathogens.''.

(c) PHASE-IN PERIOD.—Paragraph (5) of section 10 of the Federal Meat Inspection Act (as added by subsection (b)(5)) shall not apply until the date that is 18 months after the date of enactment of this Act.

SEC. 4. FOOD SAFETY.

(a) PATHOGEN REDUCTION TREATMENT.—Chapter IV of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding at the end the following:

''SEC. 418. PATHOGEN REDUCTION TREATMENT.

''(a) IN GENERAL.—The Secretary shall promulgate regulations requiring each facility registered under section 415 to apply pathogen reduction treatments to each food, as the Secretary determines appropriate, that such facility manufactures, processes, packages, or holds for consumption in the United States.

''(b) CERTIFICATION.—The Secretary shall promulgate regulations requiring each facility described in subsection (a) to certify to the Secretary that—

''(1) each food manufactured, processed, packaged, or held (including each ingredient of such food that is added, modified, or otherwise handled) by such facility contains no verifiable traces of pathogens; or

''(2) each food leaving such facility has received pathogen reduction treatments, as required by the regulations promulgated under such subsection.''.

(b) PHASE-IN PERIOD.—The requirements under section 418(b) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a)) shall not apply until the date that is 18 months after the date of enactment of this Act.

(c) TECHNICAL AMENDMENT.—Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) is amended by adding at the end the following:

''(j) If the facility has not provided a certification required under section 418.''.

(d) LABELING WITH RESPECT TO SPICES, FLAVORING, AND COLORING.—Section 403 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343) is amended—

(1) in paragraph (g), by striking ''(other than spices,'' and inserting ''(including spices,'';

(2) in paragraph (i), by striking ''; except that spices, flavorings, and colors not required to be certified under section 721(c) unless sold as spices, flavorings, or such colors, may be designated as spices, flavorings, and colorings without naming each'';

(3) in paragraph (k), by striking ''The provisions of this paragraph and paragraphs (g) and (i) with respect to artificial coloring shall not apply in the case of butter, cheese, or ice cream.''; and

(4) in paragraph (x), by striking ''Notwithstanding subsection (g), (i), or (k), or any other law, a'' and inserting ''A''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 361—COMMENDING REAL SALT LAKE FOR WINNING THE 2009 MAJOR LEAGUE SOCCER CUP

Mr. BENNETT (for himself and Mr. HATCH) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 361

Whereas on November 22, 2009, Real Salt Lake (RSL) won the Major League Soccer Cup in front of 46,011 fans in Seattle, Washington;

Whereas RSL overcame substantial obstacles to outplay and outlast the formidable

Los Angeles Galaxy in the championship game;

Whereas RSL began the second half trailing the Galaxy by a score of 1-0 and were also without starter Will Johnson and key playmaker Javier Morales;

Whereas Robbie Findley scored for RSL in the 64th minute to tie the game at 1-1;

Whereas RSL won by a score of 5-4 in the seventh round of penalty kicks on a shot by Robbie Russell;

Whereas RSL goalkeeper Nick Rimando made more saves than any other goalkeeper in the 2009 Major League Soccer (MLS) playoffs, as he stopped 2 penalty kicks during the final shootout and was named the MLS Cup Most Valuable Player;

Whereas RSL head coach Jason Kreis, at age 36, became the youngest manager to win a MLS title;

Whereas the MLS Cup victory capped off an improbable season for RSL, as the team accumulated an 11-12-7 record during the regular season but went on to become the first franchise in professional sports history to win a championship after finishing the regular season without a winning record;

Whereas the victory in the championship game was the second straight shootout win for RSL, after beating the Chicago Fire in the Eastern Conference Championship by a score of 5-4 on penalties;

Whereas RSL defeated the defending MLS champion Columbus Crew in the Eastern Conference Semifinals, winning 4-2 on aggregate;

Whereas Salt Lake City, Utah, has been home to RSL since the team's founding in 2005;

Whereas the people of the State of Utah have provided stalwart support for RSL and deserve to celebrate this championship, which is the first professional sports crown in the State of Utah since 1971; and

Whereas the players of RSL are good role models to young athletes for their hard work, tenacity, and determination in the face of difficult obstacles, and have served as outstanding representatives for the State of Utah both on and off the field: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates Real Salt Lake for winning the 2009 Major League Soccer Cup;

(2) recognizes the achievements of the players, coaches, and staff whose hard work and dedication helped Real Salt Lake win the championship; and

(3) respectfully directs the Secretary of the Senate to transmit an enrolled copy of this resolution to Real Salt Lake for appropriate display, as well as owner Dave Checketts and head coach Jason Kreis.

SENATE RESOLUTION 362—EXPRESSING THE SENSE OF THE SENATE THAT THE SECRETARY OF THE TREASURY SHOULD DIRECT THE UNITED STATES EXECUTIVE DIRECTORS TO THE INTERNATIONAL MONETARY FUND AND THE WORLD BANK TO USE THE VOICE AND VOTE OF THE UNITED STATES TO OPPOSE MAKING ANY LOANS TO THE GOVERNMENT OF ANTIGUA AND BARBUDA UNTIL THAT GOVERNMENT COOPERATES WITH THE UNITED STATES AND COMPENSATES THE VICTIMS OF THE STANFORD FINANCIAL GROUP FRAUD

Mr. SHELBY (for himself, Mr. VITTER, Mr. COCHRAN, Mr. CORNYN, Mrs. HUTCHISON, Mr. ISAKSON, Mrs. SHAHEEN, and Mr. WICKER) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 362

Whereas thousands of investors, many of them in the United States, lost billions of dollars that they invested in fraudulent Stanford International Bank certificates of deposit;

Whereas Allen Stanford had close ties with the Government of Antigua and Barbuda and, among other things, Mr. Stanford is alleged to have loaned at least $85,000,000 to the Government of Antigua and Barbuda, which likely came from investor funds;

Whereas the relationship of the Stanford Financial Group with the Government of Antigua and Barbuda was described in a joint statement by the Stanford Financial Group and the Cabinet of Antigua and Barbuda as a ''productive and mutually beneficial relationship'';

Whereas the United States Securities and Exchange Commission alleged that Leroy King, the chief executive officer of the Financial Services Regulatory Commission of Antigua and Barbuda, was bribed by Mr. Stanford not to investigate the Stanford International Bank, to provide Mr. Stanford with access to the Financial Services Regulatory Commission's confidential files, to allow Mr. Stanford to dictate the Financial Services Regulatory Commission's responses to inquiries by the Securities and Exchange Commission about the Stanford International Bank, and to withhold information from the Securities and Exchange Commission;

Whereas, after the fraud allegedly perpetrated by the Stanford Financial Group was made public, the Government of Antigua and Barbuda seized Stanford property in Antigua and Barbuda worth up to several hundred million dollars;

Whereas, in an October 28, 2009 report, the United States court-appointed receiver, Ralph Janvey, reported that ''the total of all cash collected is $128.8 million, of which $71.5 million remains on hand after payment of expenses'', which falls far short of investor losses;

Whereas Janvey's report also noted that ''the Antiguan liquidators object to every attempt to secure and liquidate assets, worldwide'', and ''[t]he government of Antigua refuses to recognize US orders even as to entities for which there is no other owner i.e. the Antiguan liquidators were only appointed to liquidate two of the more than 150 Stanford entities, but we are hindered by Antigua's refusal to recognize the Court's orders even as to non-disputed entities''; and

Whereas the Government of Antigua and Barbuda is seeking loans from the International Monetary Fund and the World Bank: Now, therefore, be it

Resolved, That it is the sense of the Senate that the Secretary of the Treasury should direct the United States Executive Directors to the International Monetary Fund and World Bank to use the voice and vote of the United States to ensure that any loan made by the International Monetary Fund or the World Bank to the Government of Antigua and Barbuda is conditioned on providing complete redress to the victims of the Stanford Financial Group fraud, including through—

(1) the full cooperation of the Government of Antigua and Barbuda and the liquidators appointed for the liquidation proceeding relating to the Stanford International Bank in Antigua and Barbuda with the Securities and Exchange Commission, the Department of Justice, and the United States court-appointed receiver in investigating the Stanford Financial Group fraud and marshaling the assets of Mr. Stanford and Stanford-affiliated entities;

(2) an agreement by the Government of Antigua and Barbuda to be subject to the jurisdiction and bound by the judgment of any United States court or international court that is adjudicating the claims of victims of the Stanford Financial Group fraud;

(3) the transfer of the assets seized by the Government of Antigua and Barbuda and the liquidators in Antigua and Barbuda to the United States court-appointed receiver for the benefit of victims of the Stanford Financial Group fraud;

(4) a contribution by the Government of Antigua and Barbuda to the United States receivership estate, for the benefit of victims of the Stanford Financial Group fraud, in an amount equal to the amount of any funds provided to Antigua and Barbuda by Mr. Stanford or any Stanford-affiliated entity; and

(5) a contribution by the Government of Antigua and Barbuda to the United States receivership estate, for the benefit of victims of the Stanford Financial Group fraud, in an amount equal to any payments made by Mr. Stanford or the Stanford Financial Group to officials of the Government of Antigua and Barbuda for the purpose of subverting regulatory oversight of the Stanford International Bank.

SENATE RESOLUTION 363—HONORING THE LIFE AND SERVICE OF BREAST CANCER ADVOCATE, STEFANIE SPIELMAN

Mr. VOINOVICH (for himself and Mr. BROWN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 363

Whereas Stefanie Spielman, a tremendous advocate and a true champion for the cause of breast cancer research, passed away on November 19, 2009, after a decade-long battle with breast cancer;

Whereas despite her constant battle with her own illness, Stefanie showed grace and compassion for others, touching countless lives in Ohio and beyond;

Whereas Stefanie tirelessly advocated for additional research into the prevention and treatment of breast cancer, and along with her husband, Chris, founded the Stefanie Spielman Fund for Breast Cancer Research at the Ohio State University Comprehensive Cancer Center—James Cancer Hospital and Solove Research Institute shortly after her diagnosis;

Whereas Stefanie and Chris later established the Stefanie Spielman Fund for Patient Assistance, which to date has generated more than $6,500,000 to help translate laboratory discoveries into effective treatments for breast cancer patients;

Whereas Stefanie served as an active and vital member of the James Cancer Hospital and Solove Research Institute Foundation Board;

Whereas Stefanie was actively engaged in advocacy issues, including Ohio Mammography Day, which received the strong support of former Ohio First Lady Janet Voinovich and was designated by the Ohio General Assembly as the third Thursday in October;

Whereas in 2000, Stefanie and Chris established ''Stefanie's Champions'' to honor one of the most important factors in cancer treatment—the loving and healing presence of a devoted caregiver;

Whereas Stefanie gave the first Champion award to her beloved husband after Chris put his professional football career on hold to care for her when she was first treated; and

Whereas Stefanie was a loving mother to her 4 children: Now, therefore, be it

Resolved, That the Senate—

(1) acknowledges the outstanding achievements and profound impact of Stefanie Spielman in the fight against breast cancer;

(2) commends Stefanie for her commitment to caring for others suffering from breast cancer; and

(3) celebrates her life as a wife, mother, and advocate for breast cancer awareness, research, and treatment.

SENATE RESOLUTION 364—SUPPORTING THE OBSERVANCE OF NATIONAL DIABETES MONTH

Mrs. SHAHEEN (for herself and Mr. DURBIN) submitted the following resolution; which was considered and agreed to:

S. RES. 364

Whereas there are nearly 24,000,000 people in the United States with diabetes and 57,000,000 with pre-diabetes;

Whereas diabetes contributed to the deaths of over 300,000 people in the United States in 2007, making diabetes the seventh leading cause of death;

Whereas every minute, 3 people are diagnosed with diabetes;

Whereas each day approximately 4,384 people are diagnosed with diabetes and, in 2007, approximately 1,600,000 new cases of diabetes were diagnosed in people 20 years or older;

Whereas between 1990 and 2001, diabetes prevalence in the United States increased by more than 60 percent;

Whereas over 24 percent of diabetes is undiagnosed, down from 30 percent in 2005, and 50 percent 10 years ago;

Whereas over 10 percent of adults and nearly ¼ (23.1 percent) of people in the United States age 60 and older have diabetes;

Whereas diabetes is a serious chronic condition that affects people of every age, race, income level, and ethnicity;

Whereas Hispanic, African, Asian, and Native Americans are disproportionately affected by diabetes and suffer at rates much higher than the general population;

Whereas annually, 15,000 youth in the United States are diagnosed with type 1 diabetes and approximately 3,700 youth are diagnosed with type 2 diabetes;

Whereas 1 in 3 people in the United States born in the year 2000 will develop diabetes in their lifetime, and this statistic grows to nearly 1 in 2 for minority populations;

Whereas diabetes costs the United States an estimated $174,000,000,000 in 2007, and $1 in every $10 spent on health care is attributed to diabetes and its complications;

Whereas approximately 1 out of every 4 Medicare dollars is spent on the care of people with diabetes;

Whereas every day 230 people with diabetes undergo an amputation, 120 people enter end-stage kidney disease programs, and 55 people go blind from diabetes;

Whereas there is not yet a cure for diabetes;

Whereas there are proven means to reduce the incidence of and delay the onset of type 2 diabetes;

Whereas people with diabetes live healthy, productive lives with the proper management and treatment; and

Whereas National Diabetes Month is celebrated in November: Now, therefore, be it

Resolved, That the Senate—

(1) supports the goals and ideals of National Diabetes Month, including encouraging people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease;

(2) recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for diabetes, which include—

(A) being over the age of 45;

(B) coming from certain ethnic backgrounds;

(C) being overweight;

(D) having a low physical activity level;

(E) having high blood pressure; and

(F) a family history of diabetes or a history of diabetes during pregnancy; and

(3) supports decreasing the prevalence of diabetes, developing better treatments, and working toward an eventual cure in the United States through increased research, treatment, and prevention.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2790. 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.

SA 2791. Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

TEXT OF AMENDMENTS

SA 2790. 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:

Beginning on page 436, strike line 18 and all that follows through page 439, line 20, and insert the following:

SEC. 2101. PROTECTING LOW-INCOME CHILDREN FROM HARM AND ENSURING THAT THEY BENEFIT FROM HEALTH REFORM.

(a) INTEGRATING CHIP ELIGIBILITY WITH METHODOLOGIES USED FOR OTHER SUBSIDIES WHILE PRESERVING CHIP FOR CHILDREN WHO CURRENTLY QUALIFY AND ASSURING CHIP COVERAGE FOR LOW-INCOME CHILDREN.—

(1) DEFINITION OF TARGETED LOW-INCOME CHILD.—Effective January 1, 2014, section 2110(b)(1) of the Social Security Act (42 U.S.C. 1397jj(b)(1)) is amended by striking subparagraph (B) and inserting the following:

''(B) whose family's modified gross income, as determined for purposes of allowing a premium credit assistance amount for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986, does not exceed 250 percent of the poverty line for a family of the size involved; and''.

(2) STATE PLAN ELIGIBILITY REQUIREMENT.—Section 2102(b)(1)(B) of such Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period at the end and inserting ''; and'' and

(C) by adding at the end the following:

''(v) with respect to fiscal years beginning with fiscal year 2014, may not deny eligibility or enrollment, because of excess family income, to any child whose family income is at or below the percentage of poverty level specified in section 2110(b)(1)(B), determined using the methodology described in such section.''.

(b) MAINTENANCE OF EFFORT.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

''(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN.—

''(A) FISCAL YEARS BEFORE FISCAL YEAR 2014.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2013, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on October 1, 2009.

''(B) FISCAL YEAR 2014 AND THEREAFTER.—

''(i) IN GENERAL.—Subject to clause (ii), with respect to fiscal years beginning with fiscal year 2014 a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children that are more restrictive than the eligibility methodologies or procedures, respectively, under such plan (or waiver) as in effect on October 1, 2009.

''(ii) EXCEPTION.—A State that, prior to fiscal year 2014, has an income eligibility standard, methodology, or procedure under its State child health plan (including any waiver under such plan) for children that results in children whose family's modified gross income (as determined for purposes of allowing a premium credit assistance amount for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986) exceeds 250 percent of the poverty line may modify such standard, methodology, or procedure so that it will not result in eligibility for children under the State plan in whose family modified gross income exceeds that percentage of the poverty line.

''(C) RULE OF CONSTRUCTION.—Subparagraphs (A) and (B) shall not be construed as preventing a State from applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that were in effect on October 1, 2009.''.

(c) PROTECTING CHIP CHILDREN AGAINST UNAFFORDABLE COSTS FOR ESSENTIAL HEALTH CARE.—

(1) CONTINUATION OF COST-SHARING PROTECTIONS FOR CHILDREN.—Section 2103(e) of such Act (42 U.S.C. 1397cc(e)) is amended by adding at the end the following:

''(5) CONTINUATION OF COST-SHARING PROTECTIONS FOR CHILDREN.—

''(A) IN GENERAL.—Except as described in subparagraph (B), during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act, a State shall not have in effect cost-sharing policies under its State child health plan (including any waiver under such plan) that increase premiums or out-of-pocket costs above the amounts for children of the same income

level (stated as a percentage of the Federal poverty level) under such plan (or waiver) as in effect on October 1, 2009.

''(B) EXCEPTION.—With respect to fiscal years beginning with fiscal year 2014, a State may increase cost-sharing amounts above those described in subparagraph (A) by an amount that does not exceed the median percentage increase in national household income since fiscal year 2013, as determined by the Secretary, for households with incomes at or below the percentage of poverty level specified in section 2110(b)(1)(B).

''(C) RULE OF CONSTRUCTION.—This paragraph shall not be construed to prevent a State from reducing premiums or out-of-pocket costs below the amounts described in subparagraph (A).''.

(2) EQUITABLE COVERAGE OF ESSENTIAL BENEFITS.—Section 2103(f) of such Act (42 U.S.C. 1397cc(f)) is amended by adding at the end the following:

''(4) EQUITABLE COVERAGE OF ESSENTIAL BENEFITS.—With respect to fiscal years beginning with fiscal year 2014, the State plan for child health assistance (including any waiver under such plan) may not deny (whether through a restriction on amount, duration, or scope, through excluding a category of health care services or items, or otherwise) a service or item to a child whose family income is at or below the percentage of poverty level specified in section 2110(b)(1)(B), determined using the methodology described in such section, if the State would cover or be required to cover such service or item had the child qualified for medical assistance under sub-clause (IV), (VI) or (VII) of section 1902(a)(10)(i).''.

(d) BASING FEDERAL PAYMENTS ON STATE CONDITIONS, RATHER THAN INFLEXIBLE DOLLAR AMOUNTS.—Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended by striking paragraph (16) and inserting the following:

''(16) notwithstanding any other provision of this title, for each of fiscal years 2013 through 2019, such amounts as are necessary to carry out this title.''.

(e) DEFRAYING STATE EXPANSION COSTS WITH ADDITIONAL FEDERAL DOLLARS.—Section 2105(b) of such Act (42 U.S.C. 1397dd(b)) is amended—

(1) by striking ''For purposes'' and inserting the following:

''(1) IN GENERAL.—For purposes''; and

(2) by adding at the end the following:

''(2) OPTION FOR INCREASED FEDERAL FINANCIAL PARTICIPATION BEGINNING IN FISCAL YEAR 2014.—Notwithstanding paragraph (1), beginning with fiscal year 2014, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 94 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D) of that subsection, paragraphs (8), (9), or (11) of subsection (c), or clause (4) of the first sentence of section 1905(b). A State may not qualify for an enhanced FMAP pursuant to this paragraph unless it implements—

''(A) each enrollment and retention provision described in subparagraphs (A), (B)(i), and (C) through (G), respectively, of section 2105(a)(4); and

''(B) any other practice for eligibility determination, enrollment or retention that the Secretary finds—

''(i) has a substantial impact increasing the number of eligible children who receive health coverage through State plans for child health assistance under this title or State plans for medical assistance under title XIX;

''(ii) reduces erroneous eligibility determinations under the state plans described in clause (i); and

''(iii) lowers operational administrative costs under the state plans described in clause (i).''.

(f) CONTINUING PERFORMANCE BONUSES FOR STATES THAT ENROLL LARGE NUMBERS OF ELIGIBLE CHILDREN.—Section 2105(a)(3) of such Act (42 U.S.C. 1397dd(a)(3)) is amended—

(1) in subparagraph (A), by striking ''and ending with fiscal year 2013''; and

(2) in subparagraph (E), by adding at the end the following:

''(iv) LATER APPROPRIATIONS.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for each of fiscal years 2013 through 2019, 25 percent of the amount described in clause (i), adjusted to reflect the proportionate change in Consumer Price Index for All Urban Consumers since fiscal year 2009, as determined by the Secretary.''.

(g) GIVING FAMILIES THE OPTION OF USING THEIR FEDERAL INCOME TAX RETURNS TO ESTABLISH ELIGIBILITY.—Section 6055 of the Internal Revenue Code of 1986, as added by section 1502(a) of the Patient Protection and Affordable Care Act, is amended by adding at the end the following:

''(f) USE OF INDIVIDUAL INCOME TAX RETURNS TO HELP DETERMINE ELIGIBILITY FOR SUBSIDIES.—

''(1) IN GENERAL.—For taxable years beginning not later than January 1, 2012, the Secretary shall develop forms that require all individuals filing returns with respect to income taxes under subtitle A—

''(A) to identify the members of the individual's household who lack health insurance at the time the return is filed; and

''(B) to indicate whether there are members of the individual's household who are under 19 years of age and for whom the individual requests disclosure of pertinent tax return information, pursuant to section 6103(c), to agencies determining eligibility for subsidies for purposes of helping such agencies determine whether the applicable household members qualify for subsidies.

In developing the applicable language on tax forms, the Secretary shall consult with the Secretary of Health and Human Services. The goals of such consultation shall include maximizing the form's comprehensibility to low-income taxpayers and the convenience of making such identification and indication.

''(2) TRANSFER OF INFORMATION.—When an individual identifies a household member pursuant to paragraph (1)(B), the Secretary shall promptly transfer pertinent tax return information to all agencies determining eligibility for subsidies in such member's state of residence, except that such transfer shall not take place to an agency unless it is subject to an enforceable agreement or other legal obligation that meets the Secretary's requirements for safeguarding taxpayer privacy and data security. The transfer described in this paragraph may take place through the data matching program described in section 1413(c)(2) of the Patient Protection and Affordable Care Act.

''(3) ELIGIBILITY DETERMINATION.—

''(A) IN GENERAL.—Notwithstanding any other provision of law except subparagraph (B), when an agency determining eligibility for subsidies receives the information described in paragraph (2), it shall determine such eligibility on the basis of such information and other information obtainable by data-matching, to the maximum extent possible.

''(B) EXCEPTIONS.—An agency described in subparagraph (A) shall base eligibility on information other than described in paragraph (2) (including through seeking additional information from the applicable individual or household member, if such information cannot be obtained through other means)—

''(i) to the extent that an eligibility requirement for subsidies cannot be decided based on the information described in subparagraph (A);

''(ii) if the agency has good reason to believe that the information described in subparagraph (A) is inaccurate; or

''(iii) if the information described in subparagraph (A) does not result in a finding of eligibility for medical assistance under title XIX of the Social Security Act, in which case—

''(I) the agency shall provide the individual with notice of—

''(aa) the circumstances under which such individual or applicable household members may qualify for additional assistance; and

''(bb) an opportunity to request a determination of whether such circumstances apply to the individual or applicable household members; and

''(II) if the individual requests such a determination, the agency shall ensure that the individual and applicable household members receive—

''(aa) an opportunity to provide any additional information needed to determine whether the circumstances described in subclause (I)(aa) apply;

''(bb) a determination of whether the circumstances described in subclause (I)(aa) apply (but only if the individual or applicable household members furnish requested information that is necessary to such determination); and

''(cc) receive any subsidies for which the individual or applicable household members qualify.

''(4) DEFINITIONS.—In this subsection:

''(A) HOUSEHOLD.—The term 'household' includes the individual filing the return, the individual's spouse (if any), and all dependents of the individual or the individual's spouse (if any).

''(B) SUBSIDIES.—The term 'subsidies' includes premium credits under section 36B, medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act, and cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act.

''(C) PERTINENT TAX INFORMATION.—The term 'pertinent tax information' refers to all information on the tax return that is potentially relevant to determining the applicable household member's eligibility for subsidies or that may facilitate data-matching with other records that are potentially relevant to determining such eligibility.

''(5) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to forbid the Secretary, pursuant to section 6013(c) and other applicable legal authority, or the Secretary of Health and Human Services from implementing, with respect to individuals who have attained age 19, policies and procedures similar to those described in paragraphs (1) through (3) with respect to individuals under 19 years of age.''.

(h) CONTINUING CHIP OUTREACH AND ENROLLMENT GRANTS.—Section 2113(a) of the Social Security Act (42 U.S.C. 1397mm(a)) is amended—

(1) in paragraph (2), by striking ''such amounts'' and inserting ''the amounts described in paragraph (1)''; and

(2) by adding at the end the following:

''(3) ADDITIONAL GRANTS FOR FISCAL YEAR 2012 AND THEREAFTER.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2019, for purposes of awarding grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this

title and title XIX and, with respect to fiscal years beginning with fiscal year 2014, premium credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act. Such grants and appropriations shall supplement and not supplant grants and appropriations that are made pursuant to other provisions of this section.''.

(i) SECRETARIAL REPORT COMPARING CHIP TO SUBSIDIZED COVERAGE IN THE EXCHANGE.—

(1) IN GENERAL.—Not later than March 1, 2016, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall submit to Congress a report that compares—

(A) the health plan coverage offered to eligible children in fiscal year 2015 by an average or median State plan for child health assistance under title XXI of the Social Security Act; and

(B) the health plan coverage that such children would have received in fiscal year 2015 if they were enrolled in a qualified health benefits plan through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and received all premium credits under section 36B of the Internal Revenue Code of 1986 and all cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act for which such children would have qualified if they were not eligible for child health assistance under title XXI of the Social Security Act.

(2) POLICY ANALYSIS.—If, as to an aspect of health plan coverage described in paragraph (3) (except as provided in the next sentence of this paragraph), the Secretary finds that the coverage described in paragraph (1)(A) is more favorable to families and children than is the coverage described in paragraph (1)(B), the report shall describe policy changes that would be needed to improve the latter coverage so that it reaches the level of favorability achieved by the former coverage. The analysis described in the previous sentence need not address the aspect of health plan coverage described in paragraph (3)(C)).

(3) HEALTH PLAN COVERAGE.—In this subsection, the term ''health plan coverage'' includes the following:

(A) The adequacy of covered benefits in meeting the health care needs of children, including those with special health care needs.

(B) Families' out-of-pocket and premium costs.

(C) Public-sector costs.

(D) Adequacy of pediatric provider networks.

(E) Quality of care measures focused specifically on children.

(F) Legal protections for children.

(G) Barriers to enrollment and service utilization.

(H) Interstate variation.

(I) Continuity of coverage and care.

(J) The impact of placing children and parents in different health plans.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the report required under paragraph (1) from—

(A) analyzing State programs of child health assistance under title XXI of the Social Security Act that go beyond the average or median such program; or

(B) including in its comparative analysis factors in addition to those described in paragraph (3).

(j) SAFEGUARDING PROGRAM INTEGRITY AND IMPROVING EFFICIENCY BY PROVIDING HEALTH SUBSIDY PROGRAMS WITH ACCESS TO THE NATIONAL DIRECTORY OF NEW HIRES.—Section 453(j) of the Social Security Act (42 U.S.C. 653(j)) is amended by adding at the end the following:

''(12) INFORMATION COMPARISONS AND DISCLOSURE TO ASSIST IN ADMINISTRATION OF HEALTH SUBSIDY PROGRAMS.—

''(A) IN GENERAL.—If, for purposes of administering a State's medical assistance program under title XIX, a State's children's health assistance program under title XXI, premium assistance under section 36B of the Internal Revenue Code of 1986, or reduced cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act, a State or Federal agency responsible for the administration of the program transmits to the Secretary the names and social security account numbers of individuals, the Secretary shall disclose to such agency information on the individuals and their employers maintained in the National Directory of New Hires, subject to this paragraph.

''(B) CONDITION ON DISCLOSURE BY THE SECRETARY.—The Secretary shall make a disclosure under subparagraph (A) only to the extent that the Secretary determines that the disclosure would not interfere with the effective operation of the program under this part.

''(C) USE AND DISCLOSURE OF INFORMATION BY STATE OR FEDERAL AGENCIES.—

''(i) IN GENERAL.—A State or Federal agency may not use or disclose information provided under this paragraph except for purposes of administering a program referred to in subparagraph (A).

''(ii) INFORMATION SECURITY.—A State or Federal agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of information obtained under this paragraph and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures.

''(iii) PENALTY FOR MISUSE OF INFORMATION.—An officer or employee of a State agency described in this paragraph who fails to comply with this subparagraph shall be subject to the sanctions under subsection (l)(2) to the same extent as if the officer or employee were an officer or employee of the United States.

''(D) PROCEDURAL REQUIREMENTS.—State or Federal agencies requesting information under this paragraph shall adhere to uniform procedures established by the Secretary governing information requests and data matching under this paragraph.

''(E) REIMBURSEMENT OF COSTS.—The State or Federal agency shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.''.

(k) DEFICIT REDUCTION CONTINGENCY.—

(1) IN GENERAL.—If a deficit reduction contingency applies to this section and the amendments made by this section, then there is appropriated, for each of fiscal years 2010 through 2019, to the Fund for Vulnerable Children and Families described in paragraph (2), out of any money in the Treasury not otherwise appropriated, an amount equal to 50 percent of the annualized deficit reduction contingency amount.

(2) THE FUND FOR VULNERABLE CHILDREN AND FAMILIES.—

(A) AUTHORITY TO ESTABLISH.—If a deficit reduction contingency applies as described in paragraph (1), the Secretary of Health and Human Services shall establish a Fund for Vulnerable Children and Families. Any dollars appropriated or donated to such Fund shall be used for any of the following purposes:

(i) Combating infant mortality.

(ii) Providing additional supports or services for low-income children with autism spectrum disorders or other disabilities.

(iii) Assisting in the provision of services to improve health care services (including mental health care services) for children in foster care under the responsibility of a State and homeless children.

(B) ANNUAL REPORTS.—The Secretary shall provide annual reports to the Congress that provide a full accounting of the revenue and expenditures of the Fund for Vulnerable Children and Families.

(3) DEFINITIONS.—In this subsection:

(A) DEFICIT REDUCTION CONTINGENCY.—A ''deficit reduction contingency'' applies to this section and the amendments made by this section if the Director of the Congressional Budget Office has found that such provisions, taken together (but without regard to this subsection), will cause a net reduction in the projected Federal budget deficit over the period of fiscal years 2010 through 2019.

(B) ANNUALIZED DEFICIT REDUCTION CONTINGENCY AMOUNT.—The term ''annualized deficit reduction contingency amount'' means the amount of the net deficit reduction described in subparagraph (A) divided by 10.

(l) CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period '', except as required under section 1902(e)(14)''.

SA 2791. Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) proposed an amendment 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:

On page 17, strike lines 9 through 24, and insert the following: ''ance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

''(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.''.

''Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.''.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, December 3, 2009, at 2:15 p.m. in room 628 of the Dirksen Senate Office Building to conduct a business meeting on pending committee issues, to be followed immediately by an oversight hearing on Expanding Dental Health Care in Indian Country, and a second hearing entitled ''Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services.''

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Stic Harris, a fellow in the office of Senator FRANKEN, be granted floor privileges for the duration of the debate on H.R. 3590.

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

Mr. DODD. Mr. President, I ask unanimous consent that privileges of the floor be granted for the remainder of this Congress to the following members of my staff: Joe Caldwell and Melinda Leidy.

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

Mr. CASEY. Mr. President, I ask unanimous consent that a member of my staff, Avni Shridharani, be granted the privilege of the floor for the remainder of the Senate consideration of H.R. 3590.

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

Mr. DURBIN. Mr. President, I ask unanimous consent that Jeff Peltola and Rob Paolucci, fellows in the office of Senator PRYOR, be granted floor privileges during the consideration of H.R. 3590.

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

SUPPORTING THE OBSERVANCE OF NATIONAL DIABETES MONTH

Mr. DURBIN. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 364, which was submitted earlier today.

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

The clerk will report.

The assistant legislative clerk read as follows:

A resolution (S. Res. 364) supporting the observance of National Diabetes Month.

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

Mr. DURBIN. Madam President, I ask unanimous consent that my name be added as a cosponsor of the resolution.

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

Mr. DURBIN. Madam President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 364) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 364

Whereas there are nearly 24,000,000 people in the United States with diabetes and 57,000,000 with pre-diabetes;

Whereas diabetes contributed to the deaths of over 300,000 people in the United States in 2007, making diabetes the seventh leading cause of death;

Whereas every minute, 3 people are diagnosed with diabetes;

Whereas each day approximately 4,384 people are diagnosed with diabetes and, in 2007, approximately 1,600,000 new cases of diabetes were diagnosed in people 20 years or older;

Whereas between 1990 and 2001, diabetes prevalence in the United States increased by more than 60 percent;

Whereas over 24 percent of diabetes is undiagnosed, down from 30 percent in 2005, and 50 percent 10 years ago;

Whereas over 10 percent of adults and nearly ¼ (23.1 percent) of people in the United States age 60 and older have diabetes;

Whereas diabetes is a serious chronic condition that affects people of every age, race, income level, and ethnicity;

Whereas Hispanic, African, Asian, and Native Americans are disproportionately affected by diabetes and suffer at rates much higher than the general population;

Whereas annually, 15,000 youth in the United States are diagnosed with type 1 diabetes and approximately 3,700 youth are diagnosed with type 2 diabetes;

Whereas 1 in 3 people in the United States born in the year 2000 will develop diabetes in their lifetime, and this statistic grows to nearly 1 in 2 for minority populations;

Whereas diabetes costs the United States an estimated $174,000,000,000 in 2007, and $1 in every $10 spent on health care is attributed to diabetes and its complications;

Whereas approximately 1 out of every 4 Medicare dollars is spent on the care of people with diabetes;

Whereas every day 230 people with diabetes undergo an amputation, 120 people enter end-stage kidney disease programs, and 55 people go blind from diabetes;

Whereas there is not yet a cure for diabetes;

Whereas there are proven means to reduce the incidence of and delay the onset of type 2 diabetes;

Whereas people with diabetes live healthy, productive lives with the proper management and treatment; and

Whereas National Diabetes Month is celebrated in November: Now, therefore, be it

Resolved, That the Senate—

(1) supports the goals and ideals of National Diabetes Month, including encouraging people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease;

(2) recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for diabetes, which include—

(A) being over the age of 45;

(B) coming from certain ethnic backgrounds;

(C) being overweight;

(D) having a low physical activity level;

(E) having high blood pressure; and

(F) a family history of diabetes or a history of diabetes during pregnancy; and

(3) supports decreasing the prevalence of diabetes, developing better treatments, and working toward an eventual cure in the United States through increased research, treatment, and prevention.

ORDERS FOR TUESDAY, DECEMBER 1, 2009

Mr. DURBIN. Madam President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. tomorrow, Tuesday, December 1; that following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, for debate only, until 11:30 a.m., with the Republicans controlling the first 30 minutes and the majority controlling the next 30 minutes, and with the remaining time equally divided and controlled between the two leaders or their designees, and with Senators permitted to speak therein for up to 10 minutes each; further, that at 11:30 a.m. the Senate proceed to executive session to consider the nomination of Calendar No. 487, Jacqueline Nguyen, as provided for under the previous order; and finally, I ask that the Senate recess from 12:30 until 2:15 p.m. to allow for the weekly caucus luncheons.

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

PROGRAM

Mr. DURBIN. Madam President, under a previous order, at 12 noon, the Senate will proceed to vote on the confirmation of the Nguyen nomination. That will be the first vote of the day.

Following the recess for the caucus luncheons, the Senate will resume consideration of the health care reform legislation. Additional rollcall votes are expected to occur throughout the day.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. DURBIN. Madam President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 6:55 p.m., adjourned until Tuesday, December 1, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF STATE

ALLAN J. KATZ, OF FLORIDA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE PORTUGUESE REPUBLIC.

IAN C. KELLY, OF MARYLAND, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE U.S. REPRESENTATIVE TO THE ORGANIZATION FOR SECURITY AND COOPERATION IN EUROPE, WITH THE RANK OF AMBASSADOR.

BISA WILLIAMS, OF NEW JERSEY, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF NIGER.

RAUL YZAGUIRRE, OF MARYLAND, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE DOMINICAN REPUBLIC.

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

PATRICK K. NAKAMURA, OF ALABAMA, TO BE A MEMBER OF THE FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION FOR A TERM OF SIX YEARS EXPIRING AUGUST 30, 2010, VICE ROBERT H. BEATTY, JR., TERM EXPIRED.

PATRICK K. NAKAMURA, OF ALABAMA, TO BE A MEMBER OF THE FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION FOR A TERM OF SIX YEARS EXPIRING AUGUST 30, 2016. (REAPPOINTMENT)

DEPARTMENT OF JUSTICE

BARBARA L. MCQUADE, OF MICHIGAN, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF MICHIGAN FOR THE TERM OF FOUR YEARS, VICE STEPHEN JOSEPH MURPHY III, RESIGNED.

JAMES L. SANTELLE, OF WISCONSIN, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF WISCONSIN FOR THE TERM OF FOUR YEARS, VICE STEVEN M. BISKUPIC, RESIGNED.

THOMAS GRAY WALKER, OF NORTH CAROLINA, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF NORTH CAROLINA FOR THE TERM OF FOUR YEARS, VICE GEORGE E. B. HOLDING.

CHRISTOPHER A. CROFTS, OF WYOMING, TO BE UNITED STATES ATTORNEY FOR THE DISTRICT OF WYOMING FOR THE TERM OF FOUR YEARS, VICE KELLY HARRISON RANKIN.

WILLIE LEE RICHARDSON, JR., OF GEORGIA, TO BE UNITED STATES MARSHAL FOR THE MIDDLE DISTRICT OF GEORGIA FOR THE TERM OF FOUR YEARS, VICE THERESA A. MERROW, RESIGNED.