United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

Vol. 155 WASHINGTON, SUNDAY, DECEMBER 6, 2009 *No. 181*

House of Representatives

The House was not in session today. Its next meeting will be held on Monday, December 7, 2009, at 10:30 a.m.

Senate

SUNDAY, DECEMBER 6, 2009

The Senate met at 12:30 p.m. and was called to order by the Honorable MARK BEGICH, a Senator from the State of Alaska.

PRAYER

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

Let us pray.

Eternal Lord God, the source of our strength, as we labor this weekend, we are grateful for Your keeping power. Lord, You sustain us and this land we love through dangers seen and unseen. Your faithfulness and mercy astound us, for throughout our Nation's history, Your loving providence has guided us through sunshine and storms.

Today, accompany our Senators in their work. May they feel Your presence, hear Your whisper, and follow Your leading. Remind them of the momentous nature of the work they seek to accomplish, as they remember that history will critique their labors. Help them also to take solace in the fact that they are ultimately accountable to You. We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK BEGICH led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 6, 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 BEGICH, a Senator from the State of Alaska, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

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

RECOGNITION OF THE ACTING MAJORITY LEADER

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

SCHEDULE

Mr. DURBIN. Mr. President, following leader remarks, the Senate will resume consideration of H.R. 3590, the health care reform legislation. The time until 3:15 p.m. will be equally divided. The majority will control the first hour, the Republicans will control the next hour. The remaining time will be equally divided and controlled between the two leaders or their designees.

At 3:15 p.m., the Senate will proceed to vote in relation to the Lincoln amendment, No. 2905, related to executive compensation, to be followed by a vote in relation to the Ensign amendment, No. 2927, relating to attorney's fees.

We are working on the next amendments in order and hope to have them ready for votes this afternoon. Senators will be notified if additional votes are scheduled after the votes at 3:15 p.m.

RECOGNITION OF THE MINORITY LEADER

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

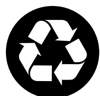
HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, first, I wish to extend a welcome to the President, who is coming to the Capitol today to meet with Democrats on the subject of the health care bill.

So far, they have voted to cut Medicare three times—cuts they previously described as immoral and irresponsible; cuts that made it impossible for the President to keep his pledge that people who like their plans can keep them; cuts that will reduce the quality of home health care; cuts that will reduce benefits for nearly 11 million American seniors on Medicare Advantage; cuts that raid Medicare instead of fixing it; and cuts the American people vehemently oppose.

Democrats are in a tough situation on this bill. They want to expand the government's reach into health care, but they do not have the money, and they don't have the support, more importantly, of the American people. So

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



Printed on recycled paper.

what did they do? They decided to take the money they need out of Medicare, and that has only made their health care plan even less popular with the American people.

The Gregg amendment, which we will vote on later this afternoon, will help reverse the damage of last week's votes. The Gregg amendment says Democrats can't raid Medicare, which is already in serious trouble, in order to pay for their $2.5 trillion bill. The money going out of Medicare's hospital insurance trust fund already exceeds its annual income. It is already drying up. By 2017, the hospital insurance trust fund will not be able to pay full benefits, and that is before our colleagues get their hands on it. This program needs to be fixed, not pillaged to create another one.

So the Gregg amendment prohibits using money from Medicare to pay for any new government programs, for expanding existing programs, or for subsidies. Instead, it directs that any money from Medicare be put back into Medicare to strengthen and preserve it for future generations so we can keep our promises. Frankly, this is common sense.

Americans don't want this bill to pass, and they certainly don't want it to pass at the expense of the roughly 40 million American seniors who depend on Medicare. The Gregg amendment would keep that from happening. A vote for the Gregg amendment is a vote to keep our promise to seniors.

We are also going to have a vote today on the Ensign amendment. The amendment is simple: It is designed to ensure that injured patients—not their lawyers—receive the vast majority of any settlement in a medical malpractice suit. It says that since lawsuits should benefit patients, not lawyers, lawyers can't take more than one-third of the recovery their clients receive. In other words, the lawyers can't take more than one-third of what the client gets.

These are responsible limits. Moreover, they were written by a Democrat and supported in the past by 21 of our current Democratic colleagues, as well as the Vice President, and they would drive down costs, which was the original purpose of reform.

The independent Congressional Budget Office has said comprehensive liability reforms would save the taxpayers more than $50 billion. The Ensign amendment is a step in that direction.

We will offer a better, step-by-step reform to end junk lawsuits against doctors and hospitals later in the consideration of this bill. I am hopeful my Democratic colleagues will support it again, since so many of them have supported it in the past.

I yield the floor.

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

Mr. DURBIN. Mr. President, I ask unanimous consent to speak as in leader time.

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

HEALTH CARE REFORM

Mr. DURBIN. Mr. President, Senator REID contacted me earlier today and said he was unable to be here for the opening of the session, and I told him I would be here to open.

I would like to say, briefly, in response to the comments that have been made by the minority leader, Senator MCCONNELL, who continues to raise the question about the future of Medicare, that I hope the Senator is sensitive to the fact that this last week, on December 3, we voted 100 to 0 for the amendment offered by Senator BENNET of Colorado, which said nothing in the amendments to this act shall result in the reduction of guaranteed benefits under the Social Security Act provisions related to Medicare; and we went on to say any savings would be used to extend the solvency of the Medicare trust fund, reduce Medicare premiums and other cost sharing for benefits and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

We voted 100 to 0, in a bipartisan fashion, to make certain we protect the Medicare Program. That is the way it should be, and that is the way the Senate voted.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

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

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the cases 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.

Lincoln amendment No. 2905 (to amendment No. 2786), to modify the limit on excessive remuneration paid by certain health insurance providers to set the limit at the same level as the salary of the President of the United States.

Ensign amendment No. 2927 (to amendment No. 2786), relative to limitation on amount of attorney's contingency fees.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 3:15 p.m. will be for debate with respect to amendment No. 2905, offered by the Senator from Arkansas, Mrs. LINCOLN; and amendment No. 2927, offered by the Senator from Nevada, Mr. ENSIGN, with the time equally divided and controlled, with Senators permitted to speak for up to 10 minutes, with the majority controlling the first 60 minutes and the Republicans controlling the next 60 minutes.

The Senator from Florida.

Mr. NELSON of Florida. Mr. President, I wish to speak on the bill and, in part, respond to the minority leader. At the end of the day, why are we staying around the clock discussing this bill with the intent that we are going to pass the bill? It is simply that we cannot continue as we are. We are in a system whereby insurance is not solving the Nation's health needs.

All you have to do is talk to a doctor. If they haven't already pulled their hair out, they are about to, in that when they want to give a certain treatment to a patient, they feel like they have to negotiate with the insurance company. In fact, the insurance company often is dictating to them what treatment and what drugs they can or cannot use or look at the simple little cases we hear about.

They are absolutely simple cases but end up with catastrophic results because someone is in the middle of a treatment for something and then they get a notice that their insurance company is going to cancel them or, perhaps, they have lost their job and they are desperately trying to get health insurance again and an insurance company uses, as an excuse, that they had a preexisting condition. It may be a flimsy excuse. I gave the example yesterday of a reason for denial being something as silly as a skin rash as a preexisting condition and so they can't get health insurance now on their own. We have a system that is out of control.

We hear a lot about cost out here. We hear a lot about cost. Indeed, if we don't do something about the cost of health care, none of our people are going to be able to afford it. Talk to corporate America and the CEOs and listen to them as they describe what the insurance companies are saying to them and how they are jacking up their rates on their employer-sponsored group policies. Please, pray that you are not an individual who can't get a group policy and you are having to go out there and try to find an individual policy because the likelihood is you are not going to be able to afford it.

So cost is a critical factor. It is a factor also to the Government because the U.S. Government cannot afford the cost of Medicare as it keeps exploding into the future. We have to bring these costs under control. When you mix that in with the horror stories that we hear of the 46 million people who don't have health insurance but who, when they get sick, end up in the emergency room, we know they are getting that care at the most expensive place while the rest of us pay. That is a hidden tax.

On average, in this Nation, that hidden tax is $1,000 per family's health insurance policy. I can tell you, in my State of Florida it is even higher. It is $1,400. In Florida, a family with a group

insurance policy is paying $1,400 more per year to take care of those folks who do not have insurance but end up getting sick, and that bill is paid by everybody else.

What I have described is a system that is in tilt. It is not working. The whole purpose of this bill is to try to make it work so, No. 1, it is affordable; No. 2, that health insurance is available. At the end of the day, we are going to pass it. At the end of the day, poor old HARRY REID, our majority leader, is going to figure out a way to get 60 of us to come down here to shut off the filibuster so we can go to final passage and get it down to a conference committee in the House. At the end of the day, after that conference committee comes back, we are going to get those 60 votes again because this is so desperately needed, despite all the supposed arguments we hear from the other side.

Can this product be improved? Of course it can. I certainly wish to share, as I did in the Finance Committee, an amendment that would cause the pharmaceutical industry to come up with some more money.

They have made a pledge, to their credit. Let me just say that Billy Tauzin, the head of the pharmaceutical association, is smart. He knows what he is doing, and he is trying to play ball with the leadership and the White House. I want the pharmaceutical industry to know this Senator appreciates that because with everybody else, such as the insurance industry, trying to kill it deader than a doornail, at least they are helping. But the pharmaceutical industry said they were coming forth with $80 billion over 10 years that they were going to contribute. The hospital industry said they were going to contribute about $150 billion over 10 years, and so forth. But, in fact, the pharmaceutical industry is not contributing $80 billion.

Here is a Morgan Stanley analysis for investors of pharmaceutical stocks. This is their analysis of what is going to happen to the pharmaceutical industry in the future. Morgan Stanley has said these guys are so smart, they are not contributing $80 billion. They are contributing only $22 billion. Why? Because when they say they are going to contribute discounts to allow half of this so-called doughnut hole to be filled, that means there is going to be a lot more drugs sold.

Oh, by the way, the bill takes Medicaid from 100 percent to 133 percent. That is going to mean a lot more drugs sold as a result of this bill.

So the real loss, or contribution, if you will, of the pharmaceutical industry is $22 billion over 10 years, not $80 billion. That does not even include—remember, they just raised their prices 9 percent, three times the rate of inflation. So they are going to make up a lot of that anyway.

What I want to plead with the leadership in the White House and the leadership of the pharmaceutical industry—come back to your $80 billion real figure over 10 years. One way to get there is the amendment I offered in the Finance Committee that was rejected on a narrow vote of 13 to 10. Out here on the floor it is my intention to offer that amendment. I filed it. It would produce, according to the CBO, $106 billion of taxpayer fund savings over 10 years because the discounts would have to be there for the Medicaid recipients who are entitled to discounts, but now, since they buy their drugs through Medicare, they can't get those discounts. That is because we changed the law 6 years ago in the prescription drug benefit. That is just simply not right.

I am not out here to try to punish anybody. I am out here to try to make this work and to get 60 votes so we can go to final passage. But everybody has to do their part. Everybody has to contribute for their part.

I look forward to the future discussions as we close in on what probably is going to end up being the final passage of this, probably a week or 8 days down the road.

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

The Senator from Pennsylvania is recognized.

Mr. SPECTER. Mr. President, the schedulers have allocated 15 minutes to me, so I ask unanimous consent at this time that I may speak for up to 15 minutes.

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

Mr. SPECTER. Mr. President, I have sought recognition to speak in opposition to the Ensign amendment. The authoritative statement on attorney's fees has come from the National Association of Insurance Commissioners in a 2008 document entitled ''Countrywide Summary of Medical Malpractice Insurance.'' These are authoritative figures on how much the defense lawyers have taken and how much the plaintiffs' lawyers have taken.

It shows that the plaintiffs' lawyers, on this state of the record, are underpaid—paid less than defense lawyers—hardly the cause for an amendment to lower attorney's fees even more for plaintiffs' lawyers.

These are the statistics by the National Association of Insurance Commissioners as to the attorney's fees. The attorney's fees for defendants were $2.110 billion. The total recovery by plaintiffs was $4.09 billion. Calculating attorney's fees at one-third would mean that the attorney's fees were, for the plaintiffs' attorneys, $1.340 billion, substantially under the $2.110 billion for defense attorneys.

Attorneys who take on cases on a contingent fee do so because, unlike insurance companies which have the funds to retain lawyers on an hourly basis, most plaintiffs are unable to pay attorney's fees, do not have the capital to do so. The arrangement is worked out that the fee will be paid by a share of the recovery. If there is no recovery, there is no fee. Beyond the absence of the fee, the plaintiffs characteristically cannot afford the costs of litigation. When depositions are taken or filings are made or various other costs arise, it is up to the plaintiff's lawyer to pay those fees and those are not reimbursed.

An effort is being made now to have those deductions on an annual basis. The plaintiff's attorney cannot even take them in the year when they are paid. So if you see a situation where, in absolute dollars plaintiffs' lawyers on contingent fees are paid less than defense lawyers, and you have added to that the risk factor that the plaintiff's lawyers may get nothing, there should even be a greater compensation for plaintiffs' lawyers than defense lawyers. As these statistics show, it is less.

Most of my experience in the courtroom has been as a prosecuting attorney, but some experience—I worked for a big law firm, Barnes, Dechert, Price, Myers and Rhoads, representing the Pennsylvania railroads, defendants, representing insurance companies. In the firm practice in that kind of representation, there is frequently a senior lawyer, junior lawyer, associate, paralegal, and multiple tiers running up the costs.

Most plaintiffs' lawyers do not have large firms. Many are single practitioners. To postulate a situation where the fees be cut even further is just not reasonable or not realistic.

When the contention has been made—it was just made by the Republican leader, repeated earlier contentions—that there are Senators who voted in favor of the Kennedy bill on liability reform, it is not so as represented. First of all, Senator Kennedy's bill in 1995 was a much different bill. Second, it was a tabling motion. Those who voted against tabling were willing to consider the issue, not that they agreed with what was in the bill. Procedurally, when there is a motion to table, if it is passed the bill is off the floor. If a motion to table is defeated, then the bill remains on the floor for consideration. But it does not mean that people who want to consider the bill are in agreement the bill ought to be enacted.

The issue of attorney's fees and the issue of malpractice litigation ought to be left to the States in our Federal system. Pennsylvania, my State, is illustrative of the way State governments can handle the issue and deal with it to avoid excesses. In Pennsylvania there was a rule change made to require that before a malpractice suit could be brought, there had to be a certification from a doctor that the case fell below applicable standards of care. A second major change was made which required that the medical malpractice action be brought only in the county where the cause of action took place. That was a move aimed at eliminating so-called venue shopping, to go to a venue where there is likely to be a better result.

As a consequence of these two rule changes, the number of filings in Pennsylvania dropped dramatically. With the comparison of the years 2000 to 2002, it was noted that the rates dropped by more than 37 percent in 2003, continued to decline in every succeeding year, and in 2008 had dropped 41.4 percent.

The improvement in the picture was further illustrated by the fact that the reforms resulted in the reduction of premiums on malpractice insurance. These reductions are in sharp contrast to 2002, when one leading carrier increased its rates an average of 40 percent and a second leading carrier increased its rates by 45 percent. Then the rates have been decreased consistently and in ensuing years.

Other indications in the success of Pennsylvania was the renewed interest of companies that want to sell medical malpractice insurance in Pennsylvania—57 newly licensed entities are now writing medical malpractice coverage since April, 2002. This is illustrative of the way the States can deal with this issue. It ought to be left to the States.

Interestingly, the Senator from Nevada, who has proposed this amendment, has filed legislation this year, S. 45, and in S. 45 he has a different approach. He allocates for some recoveries up to 40 percent. Why there is a difference now, cutting it back to 33 percent, and then down to 25 percent, is unexplained. But when an amendment of this sort is offered on a bill for comprehensive health care reform, it is not germane to the issues before the Senate. The standard of being germane means whether there is any provision in the bill now which relates to this matter.

Had this really been a serious effort to get legislation, the process or recourse to be followed would have been considerably different. The way to get legislation enacted is not merely to come before some bill and offer it without hearings before the committee of jurisdiction, without the consideration of witnesses. There have been no hearings on the amendment offered by the Senator from Nevada. Had there been hearings we would have been in a position to make a determination as to what are the real facts.

Are the fees collected by plaintiffs' attorneys on a contingent basis excessive? What is the reality for the justification, in terms of the time it takes and the expenses involved? But no request was made, to my knowledge, for a hearing before the Judiciary Committee. I do know that no hearing was held. So we do not have a factual basis for making an evaluation of this amendment at this time.

It is my hope that we will move from this amendment and take up the issues which are in dispute. We need to eliminate and reject the false rumors which have been advanced. The contention has been made that there would be death panels as a result of this bill. That has been thoroughly debunked. There has been a context that there would be cuts in Medicare. We argued an amendment a few days ago on the contention that there would be very substantial cuts in Medicare. The AARP opposed that amendment because it was fallacious. It was untrue. AARP is an outstanding guardian of the interests and rights of senior citizens, and AARP opposed that amendment.

The contention has been made that there will be a government takeover of medical care which has also been disputed and pretty well disproved. When the government option is offered, it is just that. I believe America would be well served by having a robust public option. But the option is nothing more or less than what it says. It is one alternative. Private insurers would still be in the picture.

There have been repeated contentions that there will be an increase in the deficit. President Obama is pledged not to sign a bill which will add to the deficit. I am pledged not to vote for a bill which will add to the deficit. When you take a look at what this bill will accomplish, there are very substantial savings in the current cost of medical care, which is $2.4 trillion. I will be specific in what they are. With annual examinations available and incentives for people to take annual examinations, they will be catching what could turn out to be chronic ailments, very disabling, very expensive. Catching a problem with a cardiac issue, with a heart problem, or catching breast cancer at an early stage or catching Hodgkin's at an early stage—I speak with some experience about this issue—will cut down medical expenses tremendously. When there are advance directives, there will also be additional savings. This bill provides for counseling for people who want to know about advance directives. No one should tell anyone else what they ought to do about end-of-life medical care, but it is fair to say consider it, make a decision, have a living will, do not leave it to the last minute when someone is rushed to the hospital and the burden then falls on family members. Estimates range as high as 27 percent of Medicare costs in the last few days, few weeks of a person's life.

There are also very substantial savings available for changes in lifestyle. Safeway has demonstrated lower insurance premiums for people who stop smoking, lower insurance premiums for people who have lower cholesterol. That is another major area of savings.

An additional area of savings would be to change the current approach of having fines imposed for Medicare.

I ask unanimous consent for 30 additional seconds.

The PRESIDING OFFICER (Mr. BINGAMAN). Without objection, it is so ordered.

Mr. SPECTER. Currently the criminal justice system results most of the time in fines for health care fraud. That is totally ineffective. But if there were jail sentences imposed, that would be a deterrent to others, something I learned years ago as a prosecuting attorney. We can also come to terms on the abortion issue, allowing women to pay for abortion coverage in their medical care. There is no reason they should be denied in maintaining the principles of the Hyde amendment with no federal payment for abortion services.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from the Commonwealth of Pennsylvania for his opening remarks. He has addressed an issue relative to a pending amendment offered by the Senator from Nevada. He makes note of a very critical flaw in this amendment. The Senator from Nevada is restricting the ability of the victims of medical malpractice to go to court to recover by restricting the attorney's fees that can be paid, contingency fees, because people usually don't have enough money to buy an attorney. The attorney takes the case and says: If you win, then I get paid. If you lose, I don't get paid. Contingent fee basis.

The Senator from Nevada is restricting the ability of these attorneys to represent plaintiffs, victims, on a contingency fee basis, but does not restrict the defense attorneys and the amount they are paid. As the Senator from Pennsylvania noted, the record is clear, the amount of money being paid to defense attorneys in medical malpractice cases is 50 percent higher on an annualized basis than that paid to those representing victims.

I won't question the motive of the Senator from Nevada, but the effect of his amendment is to reduce the likelihood that an injured victim will be able to go to court and be represented by an attorney to make their claim. Our system of justice has a courtroom and jury and a judge there to make that final decision. What the Senator from Nevada does is preclude and reduce the possibility that victims can recover. How many people die each year in America from medical malpractice? The Institute of Medicine told us 10 years ago the number was 98,000 people a year. Many more are injured because of medical malpractice. How many lawsuits, claims are successfully filed each year in America for medical malpractice, for injuries and deaths? About 11,000. A very small percentage of the actual victims of malpractice go to court. It doesn't happen. Those who try to go to court are usually not rich people so they do it on a contingency fee. What the Senator from Nevada is trying to do, unfortunately, is to close the courthouse door to favor the defense of a malpractice case over the victim. That, to me, is unfortunate, and I hope we are successful in defeating it. For those who are following the proceedings of the Senate today, either in person or through C–

SPAN, it is an unusual—not unprecedented but unusual—meeting on Sunday. But it is appropriate that we would do something extraordinary when you consider the matter at hand. This 2,000-page bill is the health care reform bill that has been in the works now for a year. It has been considered by three committees in the House and two in the Senate. The Presiding Officer from New Mexico has the dubious distinction of having been privy to all of the Senate committee proceedings and some extraneous proceedings. He has probably been subjected to more debate on this issue than any other Member.

A lot of hard work has gone into this bill. Some critics say it is too long. There are too many pages. When you consider that we are tackling our health care system, which comprises one-sixth of our gross domestic product—$1 out of every $6 spent in America—it is understandable that we would need to work carefully and try in a comprehensive way to address all the issues.

So what does this bill do? First, it is historic in that it moves us toward 94 percent of the American people having health insurance. Today about 50 million people don't have health insurance. That is not counting the people with bad health insurance. These are people who have no health insurance. Some have lost jobs, some worked for businesses that can't afford insurance, and some can't afford to buy it themselves, 50 million of them. Thirty million are going to move toward coverage in this bill. It will be the largest percentage of Americans with the security of health insurance protection in our Nation's history. That is what this bill does.

Secondly, this bill makes health insurance premiums more affordable. For over 80 percent—some say over 90 percent—of the people in America, they will see either a reduction in premium or a slowdown in the rate of growth in health insurance premiums. That is something that is absolutely essential because health insurance premiums are breaking the bank. Ten years ago, the average health insurance plan for a family of four cost $6,000 a year. That is a lot of money, $500 a month. That was 10 years ago. Now it has doubled. The average is $12,000 a year, $1,000 a month for a family of four for health insurance coverage. That is the average, to work and earn $1,000 a month strictly for health insurance. What is the projection in 8 years? That it will double again to $24,000, that you will be working and earning $2,000 a month just to pay for health insurance. That is unaffordable for so many people. That is why that is one of the highest priorities in this bill.

The third thing this bill does is to give people across America a fighting chance against the health insurance companies. These private insurance companies are some of the wealthiest companies in America and pay the highest amounts to their CEOs each and every year. What we are trying to do is to make sure they don't turn down people when they need help the most. Too many of these insurance companies, as has been noted many times, raise the issue of preexisting conditions and say: We are not going to cover that particular surgery or that particular drug because you had a preexisting condition you didn't disclose. They game the system against the person who is sick. That is going to change. This bill will provide for coverage despite preexisting conditions, and we won't allow the insurance companies to assert a limit, a lifetime limit on what they can pay.

You know what happens. You get seriously ill, and they cut you off. What is happening today is that two out of three people who file for bankruptcy in America do so because of medical bills, bills they can't pay. That tells us that the number of people facing this threat is huge. But even worse is the fact that some 74 percent of those filing bankruptcy already have health insurance. It turns out the health insurance was not worth much when they needed it.

The last thing this bill does—and one of the most important things—is it doesn't add to the deficit. President Obama told us to do this job but don't make the deficit worse. The Congressional Budget Office, which is the referee and umpire when it comes to the cost of bills, came back and said our bill will actually reduce the Federal deficit by $130 billion over the first 10 years and $650 billion over the next 10. Bringing down the cost of health care brings down the cost of government health programs. It saves us money, saving families and businesses money, saving the government money. It is the largest deficit reduction bill ever considered by Congress. It is before us now.

It is no surprise—we heard this morning from the Republican Senate leader, and we have heard before—that there are those who are arguing this is a dangerous bill and this bill should not be passed. I asked my staff to do a little bit of work on previous debates right here on the floor of the Senate and what was said.

In 1934, when Congress was considering the Social Security Program, which gave everybody a basic retirement plan, an insurance plan for retirement, even after the Social Security bill came to the Senate floor, not including health insurance, a Republican Senator from Delaware, Daniel Hastings, said on the floor about Social Security:

> I fear it may end the progress of a great country.

A Congressman from the State of New York, James Wadsworth, in the same debate over Social Security, said that the passage of Social Security:

> . . . opens the door and invites the entrance into the political field of a power so vast, so powerful as to threaten the integrity of our institutions and to pull the pillars of the temple down upon the heads of our descendants.

We know that when former Senator from Ohio Robert Taft was addressing the effort by President Harry Truman to have universal health care in America, he said:

> I consider it socialism.

It was used against Lyndon Johnson. That same charge was used against Bill Clinton. It is virtually being used today. When we hear the Republicans who are opposing this bill come to the floor, I have a basic question to ask them. We have been at this debate for a year. Where is your bill? What do you want to do?

Oh, they tell us: We have some bills, and you are going to see them any day now. Well, I would like to. I would like to see the comprehensive health reform bill from the Republican side of the aisle. This is ours, and it has been on the Internet for 2 weeks for everybody in this Nation to read word by word, line by line. Sadly, there is no Republican bill.

I know there are two possible reasons for that. This was hard work. This was not easy politically or otherwise and they have not engaged in that hard work. What we have seen are press releases and speeches, graphs and pictures, but no bill, no comprehensive health care reform bill from the Republican side. Secondly, there are many on that side of the aisle who like this system of health care. They agree with the health insurance companies: Let's keep it the way it is.

But Americans know better. We are going to work today in the Senate on this bill, as we should. While we are working today, 14,000 Americans are going to lose their health insurance. Mr. President, 14,000 Americans lost their health insurance yesterday, and 14,000 will lose it tomorrow, and every single day of the year. That is how many people, despite their best efforts, lose their coverage.

We have to stop that. It is time for us to provide the kind of peace of mind that every single family deserves in America when it comes to quality and affordable health care.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

AMENDMENT NO. 2927

Mr. CASEY. Mr. President, I rise this afternoon to speak about one of the amendments we are going to be voting on later today. As we stand here today, we are debating the bill on the floor, the health care bill, where we are trying to do a couple things at one time, and I think we can, and I think this bill does it, even though we will make some changes to it.

We are trying to improve the quality of care for Americans, whether they get their health care through a public program or through a private insurance company or a private plan. We are trying to finally use preventive measures to make people healthier and have better health outcomes.

We are also working to reduce costs. If you want to talk about it in terms of a doctor and a patient or a health care system and an American, who should benefit from the health care system, we basically want to have people get the care they need from the doctor they choose.

What we are engaged in now is a debate about an amendment which the other side says is about the fees going to trial lawyers. That is the way they like to talk about it, and I know that is popular. When the other side makes an amendment such as this, they like to have a target, so their target is trial lawyers. But, unfortunately, for this debate, I think it is misleading because this amendment, which I would urge people to vote against, is not about lawyers. It is about victims and whether we are going to ensure that victims have a shot, a fair chance, when they have a claim for medical negligence when they have been injured as a result of negligent conduct.

I said before, we are debating the health care bill and we are talking about costs. This amendment will do nothing to lower costs. What it will do is not lower anyone's costs. What it will do is increase the cost or the burden a claimant has to bear when they have a claim against any kind of hospital or doctor in the case of a medical negligence case. So the question is, are we going to enable people who do not have the means to bring cases versus very powerful interests? That is one of the basic questions we will answer with regard to this amendment.

I would hope if a member of my family or any family—and I think this is true of everyone in this Chamber—if a member of your family, as a result of medical negligence, had to bring a claim, you would hope that individual could walk into a courtroom or file a claim with someone who has the skill and the ability to be their advocate. Because I will tell you one thing, they are going to be up against a very powerful interest: insurance companies that write medical liability policies, an incredibly powerful interest.

A lot of us come at this question through our own personal experience, through the experiences of our families. I had a grandfather who I never met, my father's father, Alphonsus Casey. He, like a lot of people in northeastern Pennsylvania, as a young kid, went into the coal mines at a very young age. He worked as a mule boy. One of the days he was tending to the mules in that mine, just as a kid, 11 or 12 years old at the time, he was kicked by a mule. He got a scar that started above his eyebrow and went across his face, split his lip, and went down through one side of his chin. So he understood injury as a child, injury in the course of working. I think he also understood that when he became a lawyer, many years later, well into his adulthood. He understood what it is like to suffer an injury and to make a claim for an injury. But what he did is represent injured workers. That was his law practice. I wonder what he would say if he were here talking about what happens to victims when they have an injury they want redress for.

Like on so many other things in this debate, I think the other side of the aisle is carrying water for the insurance companies. Just my opinion, but I think that is the case. Yet in the case of medical negligence and what happens in the real world, we know that 98,000 deaths a year are from preventable medical errors. Let me say that again. We know there are 98,000 deaths in America a year, according to the Institute of Medicine, from preventable medical errors.

So what this amendment does is deny patients the attorney of their choice. It further restricts access to the courts. It drives up costs for victims. When we talk about bringing a case and the barriers to doing that, that is not some future result of this amendment. Oh, I think this amendment will make that problem a lot worse. But right now—no matter what happens in this debate, no matter what happens on the vote on this amendment—there are barriers right now for people to bring a lawsuit. It costs, in many cases, thousands, if not tens of thousands, to bring a case. And then to see a case all the way through costs a lot more than that.

What are we talking about here? We are talking about allowing someone who has a claim for a serious injury to go see a lawyer and to sit down with that lawyer and enter into an agreement for the fee, whatever that fee will be, whatever that will be. If that lawyer and that person, that patient or victim, goes forward with the case, they bear a risk. The victim bears a risk that they will not be successful and that at the end of that they will have no recovery at all.

But because of the way the contingent fee works, the lawyer bears a risk as well that he or she will not be paid, and they also stand a risk of having to pay for costs the victim cannot pay—and the lawyer will bear those costs throughout the pursuit of that case.

So here is what we are talking about. This is basically a debate about victims and whether they are going to have the kind of representation they need. If I were going in to have surgery in a hospital, I would hope the surgeon would be someone of the best, the highest skill possible. I would want the best surgeon, as I take on that battle. Anyone would.

I would hope we would not do something in the debate to reduce the chances that a victim of medical negligence could go into a courtroom or file a claim with the best, most highly skilled lawyer they can find. I would hope we would not want to do anything that would injure that basic right.

It is interesting that this amendment applies only to patients—it does not apply to anyone else—patients who would become victims of medical negligence.

In conclusion, in terms of what happens in our States, States regulate the conduct of lawyers. They do it all the time. But we also have evidence from the States about what happens in these kinds of cases. In Pennsylvania, for example, in most counties, as to cases going to trial because of medical malpractice claims—those kinds of lawsuits—in most counties in Pennsylvania, 90 percent of those cases are won by the defense, won by the insurance company. That is the evidence in Pennsylvania.

I know we have others who are ready to speak on this and other amendments. But I think we should make it very clear. On this amendment, this is a debate about two parties: victims of medical negligence versus insurance companies. It is time to choose up which side you stand on. Unfortunately, this amendment is very clearly drafted and intended to help insurance companies, not victims of medical negligence.

I yield the floor.

I suggest the absence of a quorum.

I withhold that suggestion.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, for the benefit of all Senators, I want to take a moment to review today's program. This is the seventh day of debate on the health care reform bill. It has been nearly 2½ weeks since the majority leader moved to proceed to this bill. We have now considered 14 amendments, and we have conducted 10 rollcalls.

Between now and 3:15 this afternoon, the Senate will continue to debate the amendment by the Senator from Arkansas, Mrs. LINCOLN, on insurance company executive compensation and, at the same time, we will debate the amendment by Senator ENSIGN limiting attorney's fees. The majority controls the first 60 minutes, and the Republicans will control the next 60 minutes. At 3:15 p.m., the Senate will conduct back-to-back votes on or in relation to the Lincoln amendment and the Ensign amendment.

Thereafter, we expect to turn to another Democratic first-degree amendment and another Republican first-degree amendment. That is the lineup at this time. It is possible the Senate may vote on those next two amendments today. As a result, additional votes are possible following the two votes at 3:15.

Once again, I thank all Senators for their cooperation and courtesy on this extraordinary weekend session.

Mr. President, I suggest that Senator HARKIN be next recognized for 7 minutes.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I will have more to say about this later. But there has been so much talk about fear, fear, fear. Everybody has a fear. Let's get away from that. It is time to quit talking about fear. Let's talk about hope. Let's talk about the realities of

what is affecting people out there, what we are trying to do to make their lives better. Why do we always want to inject fear into people? Let's talk about hope. Let's talk about real people and what this bill does.

As shown in this picture, this is Sarah Posekany of Cedar Falls, IA. Let me tell you her story. It is incredible. She was diagnosed with Crohn's disease when she was 15 years old. During her first year in college, she ran into complications from the disease and had to drop classes. Because she was no longer a full-time student, her parents' private health insurance company terminated her coverage. Then the medical bills piled up. Four years later, she found herself $180,000 in debt, and was forced to file for bankruptcy.

Sarah has undergone seven surgeries—seven. Here is what is disturbing. Two of those came as a direct result of not being able to afford medication. So again, it is an incredible story, but it is a true story.

So many people have to go through this. Our bill says: Look, you can stay on your parents' coverage until you are age 26, and—guess what—no preexisting conditions will apply to you from here on out. Think about Sarah when we are talking about this bill and the hope she needs—and so many like her—that we are going to change this system to make her life better.

Second, this is a picture of Tasha Hudson of Des Moines, IA. She is a single mother, with three kids. She had a job which provided health insurance, but she took a new job that paid her more, 50 percent more. You would think: Isn't that the American way? You learn, you get better, you get a better paying job. The problem is, the private sector job did not come with health insurance. Despite the higher pay, she could not afford the coverage.

Ironically, her higher pay led to cuts in her Medicaid benefits and the loss of childcare services. As a result, Tasha is now in the process of returning to a lower paying job, despite its limited opportunities, for one reason: because it will provide health insurance for her family. These are real people. These are the people to whom we need to give hope.

Here is one last one. Eleanor Pierce lives in Cedar Falls, IA. She lost her job when her company was eliminated. She had the option of purchasing COBRA, but she couldn't afford it. So she searched for coverage, but because of high blood pressure—preexisting condition—she was denied access. So age 62, suffering from high blood pressure, she had no choice but to go without insurance.

That is why we need this bill. Not for fear—let's quit talking about fear. Let's talk about hope for the people I just talked about, the hope that their lives will be better, that they will get the insurance coverage they need, that they will be able to get on with their lives and not have to go so far in debt that they have to go into bankruptcy.

If you are a 62-year-old woman with a serious heart condition such as the one Eleanor has, high blood pressure, you just don't have a prayer, you are on your own, and the odds of premature death are disturbingly high. We can and must do better. That is what we ought to be talking about: hope for the future, not fear.

Mr. President, I yield the floor.

Mr. BAUCUS. Mr. President, I yield to the Senator from Connecticut all the remaining time, and if he wants to speak for a little longer, I know we can make some accommodations with the other side.

Mr. DODD. How much time remains?

The PRESIDING OFFICER. Eight minutes is remaining.

Mr. DODD. I thank my colleagues.

Mr. President, some of these numbers get thrown around so much that it is almost dizzying. I wonder how the average person, even someone who is intently listening to these debates, can sort it all out: 47 million who have no coverage; 14,000 people every single day in our country who lose health care coverage either because they are thrown into personal bankruptcy or because of medical costs or job loss around the country—14,000 a day, every day, 7 days a week. Just do the math. For 7 or 8 days, we have been debating this legislation. You can run the numbers yourself to determine over that period of time how many citizens across the country have found themselves in that free fall, that dreaded fear that a child or a loved one may end up needing care. It is not as though you can postpone the decision to some later time, as you can about whether to take a vacation or to buy that new car or maybe to spend more than you thought you would over the holidays coming up. If you now have a medical emergency and you are one of those 14,000 a day who have lost coverage, what do you do? So sometimes the sheer magnitude of these numbers can cause us to lose sight of the individual stories, anecdotes that are not exclusive or isolated but commonplace stories that are happening as we speak here on this Sunday, on a rare Sunday session in the Senate because of the importance of this issue.

So I rise today to share a few stories from my own State that I think put a face on these issues and why we are here. Let me start by asking some questions because I think too often when we debate these issues, sometimes we are so removed as Members of this body, from what goes on in the daily lives of the people we represent that we fail to appreciate what is happening right outside these doors from this very Chamber on a daily and an hourly occasion. The 535 of us who have the privilege of serving in the Congress, including Members of the other body, none of us here are worrying about losing our health care. Not a single Member here ever spent a nanosecond worrying about whether they are going to be dropped from their health care coverage—not one.

Is there anybody among the 535 of us who ever worries about whether we will be able to afford health care insurance? I don't know of anyone who ever worries about that, of the 535 who are here.

Has anyone ever been up late at night with a child or a loved one, wondering whether they are going to be able to afford the treatment that child may need, or that loved one? I would go so far as to say I don't think that happens here. God forbid if we are confronted with a child or a loved one who needs that care. We may worry about that, but we are not going to worry about whether the insurance will be there or whether we will have the ability to pay for it. Not one of us ever worries about that.

Has anybody ever spent hours being bounced from voice mail to voice mail to voice mail trying to find out why the insurance company you pay thousands of dollars to every year suddenly refuses to pay for your spouse's cancer treatments? Has that ever happened to anyone here? I doubt it. I sincerely doubt it.

Is there anyone stuck in a job that pays very little because you can't afford to change jobs because you have a preexisting condition and you know if you go to that new job that may pay more, you are going to find yourself without the insurance coverage to take care of that preexisting condition? No one here worries about being in that particular predicament.

Has anyone been driven into bankruptcy, any Members of Congress, because they had a medical crisis? We now know that 62 percent of all bankruptcies this year alone are medical crisis related, and 70 percent of that 62 percent have health care insurance—70 percent of that 62 percent.

Is anybody here a small business owner who has had to choose between cutting coverage or putting your employees out of work?

Well, the answer to all of these questions obviously is a resounding no. None of us have ever had to grapple with what 14,000 people do in this country every day: losing their coverage, or the underinsured who discover all of a sudden that the coverage they thought they had doesn't quite cover the problems, or the out-of-pocket expenses you have to pay before getting to insurance are so high that you can't possibly meet them. That goes on every minute of every day all across our Nation, and it is why we are here on this Sunday in December, to try to finally see if we cannot come to terms and start moving on a coverage program, a health care and health insurance coverage program that makes it possible for all of our fellow citizens to be in the same position we are.

None of us are immune from health care crises. Every one of us here has grappled with that at one time or another. The difference is, we don't ever worry about the ability to pay for it, losing our coverage, having to go through what every other citizen does every single day.

These are real people who go through this. We can get so lost in the weeds on this debate. I am not suggesting the details are unimportant—they are important—but we are losing sight of the whole; that is, for 80 years every single Congress, whether it has been controlled by Republicans or Democrats, whether a Democrat or Republican has been in the White House, has been unable to even come close to solving this problem.

We are now that close—closer than we have ever been in our history—to coming up with a health care system that can begin to take care of that basic right every American ought to have—and it is a right—that if you are a citizen of the United States and you get sick, you ought not to be shoved into bankruptcy, lose your job, or have your family suffer because of your economic circumstances. The privilege of getting good health care ought not to be based on wealth; it ought to be based on the fact that we live in the United States of America and we are able to take care of our fellow citizens when they reach those difficult times every one of us will at one point or another.

There are stories, and I know my colleagues have them as well.

A young woman in Connecticut, Maria, diagnosed with non-Hodgkins lymphoma, asked her insurance company to cover her treatments. The insurance company found out that Maria had once gone to a doctor for what she thought was a pinched nerve. Even though no tests had been done for cancer, they denied her claim based on a preexisting condition. How many have heard these stories? She passed away, by the way, from that illness.

A young man named Frank disclosed on his insurance application that he sometimes got headaches. Some months after he got his policy, he went in for a routine eye exam. The doctor saw something he didn't like and sent him to a neurologist, who told him that he had multiple sclerosis. The insurance company told him he should have known his occasional headaches were a sign of MS and took away his coverage retroactively. Frank's doctor wrote them a letter saying there was no way anyone could have known that an ordinary headache was related to multiple sclerosis. But the insurance left Frank out to dry, sticking him with a $30,000 medical bill he couldn't afford. Frank's condition got worse. He had to leave his job and go on public assistance.

Kevin Galvin is a small business owner in my State. I have met with Kevin a number of times, and we have talked over the last year or so during my Connecticut Prescriptions for Change listening tour. Kevin owns a small business, a maintenance company. He employs seven people, some older, some younger. He can't afford to insure them. He would like to, but he can't afford it. His younger employees use the emergency room as their regular doctor. If one of them has a child with an ear infection——

The PRESIDING OFFICER. The majority time has expired.

Mr. DODD. I ask unanimous consent for 1 additional minute, I ask my colleagues.

Mr. BAUCUS. I ask unanimous consent for 1 additional minute.

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

Mr. DODD. I thank my colleagues.

Kevin has three employees in their twenties and thirties. This is Kevin here, by the way, running this maintenance shop in Hartford, CT. He has employees in their twenties and thirties who have never had a physical or a dental cleaning by a hygienist. One of them, age 28, with two children to support, was out of work for 12 weeks and nearly died from a staph infection he got from an untreated cavity.

Kevin has been working hard to try to provide for these people, but he has recently lost people who worked for him for more than 20 years because they got a job that paid less than he pays them but they can get health insurance coverage. So here is an employee who leaves a job in order to get a job where he can have health insurance.

Again, small business owners who go through this are all across our country.

My simple point is this: Anyone who suggests this bill is the end-all obviously hasn't been through this process over the last several years. There will be a lot more work that needs to be done in the years to come. But we need to do what no other Congress has done before: We need to start. That is why I feel so passionately about getting this bill passed and moving it forward. I ask my colleagues to join us.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I yield 5 minutes to the Senator from New Hampshire and 10 minutes to the Senator from Texas.

Mr. GREGG. Mr. President, I ask unanimous consent that during the next hour which we control we be allowed to enter into colloquies on our side of the aisle.

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

Mr. GREGG. Mr. President, we have certainly heard a lot of talk about Medicare over the last few days, and we have actually even voted on a few amendments, but they have all had no force of law, and they have just been statements of purpose. They are called sense of the Senate. Every one of these sense of the Senate has had as its purpose to try to give political cover to Members on the other side relative to the issue of the fact that this bill reduces Medicare spending by close to $½ trillion in the first 10 years, $1 trillion when it is fully implemented over a 10-year period, and $2.5 trillion over the first 20 years, and that those reductions in spending in Medicare are going to translate immediately and unquestionably into a reduction in service and coverage for Medicare-recipient senior citizens. The money from that—the $½ trillion in the first 10 years, the $1 trillion in the 10 years that we are doing the implementation, and the $2.5 trillion over the next 20 years—is being taken out of the senior citizen program called Medicare, and it is going to be moved over into a brandnew entitlement program and into the expansion of Medicaid.

Those dollars will be used to create new Federal programs for people who have never paid, for the most part, into the Medicare hospitalization fund; for people who are not senior citizens and therefore do not, arguably, deserve to receive the benefit of the Medicare hospitalization fund. As a result, seniors will see their benefits reduced and other people will get a new benefit through the Federal Government. Ironically, the new benefit, this new entitlement, will not be adequately funded either, but large portions of part of that funding are going to come from the Medicare trust fund.

The problem here is that the Medicare trust fund is insolvent. It has $30 trillion of outstanding exposure to the Medicare trust fund, which we don't know how we are going to pay for as seniors retire over the next 20, 30, 40 years. Thus, there will be a reduction in the benefits to Medicare, a reduction to Medicare recipients, a reduction in the Medicare trust fund to the tune of $½ trillion in the first 10 years, $1 trillion when it is fully implemented, and $2.5 trillion over the next 20 years.

That type of reduction shouldn't go to create new Federal programs. If it is going to be done at all, it should go to making the Medicare trust fund more solvent. Well, that has been essentially the tenure of some of the proposals from the other side of the aisle. We have heard a lot of people on the other side of the aisle say: All right, we are not going to cut Medicare. We are not going to cut Medicare. We are just going to reduce it by $½ trillion, and then we are going to create a new program with it. We are not going to do this to the seniors. We are not going to take their money and start a new program.

We have heard that statement in different levels of machinations from the other side of the aisle quite regularly.

I do, however, for the record, want to say—because I have immense respect for him, and he has been totally forthcoming on these issues, and very accurate—that the chairman of the Finance Committee has not represented that is what is happening with the Medicare funds.

He has represented on the floor that those Medicare funds that are being reduced—those reductions in Medicare spending will go to create a new program. But a lot of folks on the other side have said they don't agree with

that, that is not what they are intending to do. Some of the sense of the Senate have clearly had that implication in their passage.

So what does that amendment do that I am going to be offering? It shoots real bullets. No longer is it a political statement, a sense of the Senate, a thought process, a virtual event saying you want to protect the Medicare trust funds. This amendment is real. It protects the Medicare trust fund. It is real hard language, which says that if you vote for this amendment, you are voting not to move Medicare trust fund dollars out of the Medicare trust fund, away from Medicare recipients, over to start a new program; that any new program started in this bill must be paid for by something other than Medicare.

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

Mr. GREGG. Mr. President, I ask unanimous consent for an additional minute.

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

Mr. GREGG. So this shoots with real bullets. It says, essentially, if you vote for this amendment, you are voting to keep the Medicare dollars with Medicare, not to take those dollars that are being cut out of senior citizen programs and move them to create a brandnew set of programs at the Federal level.

This will be the vote that I believe determines whether we raid the Medicare funds for the purpose of creating a new Federal program or whether we maintain the integrity of the Medicare system. This is a serious amendment, and it is a real amendment. There is no sense of the Senate about this. This is enforceable language. Anybody voting against this amendment is formally voting, unquestionably and unequivocally, to take $½ trillion of Medicare funds, in the first 10 years, and move them over to fund a new program; to take $1 trillion from the Medicare funds, when fully implemented, and move them to fund a new program; to take $2.5 trillion, over the next 20 years, of Medicare benefits that should be going to seniors—because they are Medicare funds and should be benefiting the solvency of the Medicare funds—and moves them to create new programs. Anybody who votes against this amendment is accomplishing that; they are cutting Medicare for the purpose of creating a new program. If you vote for the amendment, to the extent Medicare savings occur, they would not be used to fund new programs. It is a real, enforceable amendment.

The PRESIDING OFFICER (Mr. KYL). The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, the President of the United States is reportedly traveling to Capitol Hill to meet with Senate Democrats in a few moments. Unfortunately, Republicans are not invited, which follows an established pattern, where notwithstanding the public statements that Republican ideas are welcome, they have been rejected at every stage of the development of this 2,074-page bill. There were party line votes in the HELP Committee and the Finance Committee and virtually every Republican idea was rejected. The President is coming to rally our Democratic friends to basically do it in a ''my way or the highway'' sort of way. They are going to own it 1,000 percent.

I think it is perhaps very timely to recall some of the President's promises because, frankly, if the President follows the promises he made to the American people, he will not be able to sign this bill or anything similar to it.

First of all, talking about transparency, he said we are going to have negotiations around a big table on C–SPAN so people can see who is making arguments on behalf of their constituents and who is making arguments on behalf of the drug companies or the insurance companies.

The reality is, this bill was merged between the Finance bill and the HELP Committee bill—merged behind closed doors, with only three Senators present and presumably their staffs.

Another promise the President made was this:

> The plan I am announcing tonight—

This was during the joint session of Congress, I believe, we attended.

> —will slow the growth of health care costs for our families, our businesses, and our government.

This is a pledge the President made to the American people. That was his stated goal for this bill. We see something very different in this 2,074-page bill, a different reality. We see that premiums for those in the individual market—families—will be increased by 10 percent by 2016, according to the CBO. You don't have to take my word for it. It is not some insurance company talking. This is the Congressional Budget Office. Businesses that fail to comply with the job-killing mandates in the bill will face additional taxes of $28 billion—yes, during a recession when unemployment is at 10 percent. That is according to the CBO. They also say taxpayers will see Federal outlays for health care coverage increase by $160 billion over 10 years.

This is from the dean of Harvard Medical School. He said:

> In discussions with dozens of health care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health care spending.

So much for bending the proverbial cost curve. Then there is this promise—another solemn promise. The President said:

> 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—

This bill obviously does not.

> —and cut the cost of a typical family's premium by up to $2,500 a year.

As I mentioned, under the CBO score, the average premium for families in the individual market will go up by $2,100, not go down by $2,500—another promise made that will not be kept if this bill is passed into law.

Then the President talked about deficits. There has been a lot about this bill being so-called deficit neutral. If you cut enough benefits for seniors and raise taxes enough on everybody, you can produce a deficit-neutral bill. This bill will spend $2.5 trillion over the next 10 years with full implementation. President Obama's chief actuary at the Center for Medicare and Medicaid Services called the ability to sign a bill such as this, without raising the deficit, ''unrealistic and doubtful.'' David Broder, the dean of the Washington press corps, said:

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

Then there is the promise of choice. The President said the American people ought to have choice when it comes to health care, their choice of their doctors and health plans. The fact is, this bill would consign 60 million Americans to a health care ''gulag'' called Medicaid. I say that because, although Medicaid provides what some people would say is coverage, it certainly doesn't provide access. In the metroplex of Texas, the Dallas-Fort Worth area, 38 percent of doctors will not see a new Medicaid patient because of Medicaid's low rates.

Then there is this claim that it will not raise taxes. Well, the Joint Committee on Taxation indicates that 38 percent of the people earning less than $200,000 a year will see a tax increase under this bill. In other words, this is another promise the President made that will be violated if this bill is passed into law because taxes will go up for 38 percent of the people. As a matter of fact, out of that 38 percent, 24 percent of them will experience a tax increase, even after taking into account the premium tax credit that is being paid under this bill. Another promise made, another promise that cannot be kept if this bill becomes law.

Then there is this one. The President said:

> So don't pay attention to those scary stories about how your benefits will be cut. That will never happen on my watch. I will protect Medicare.

Dr. Elmendorf, the head of the CBO, said Medicare's managed care plans would see reduced benefits—I am sorry, that is according to CBS News. The chief actuary said:

> Providers might end their participation in the program, possibly jeopardizing access to care for beneficiaries.

Dr. Elmendorf said you would see additional benefits that seniors get under Medicare Advantage cut by about half. Another promise, another promise broken if this bill becomes law.

There is this, which pertains to the Ensign amendment pending on the floor. The President said:

I want to work with the American Medical Association so we can scale back the excessive defensive medicine that reinforces our current system, and shift to a system where we are providing better care simply—rather than simply more treatment. So this is going to be a priority for me.

If this is a priority for the President of the United States, it is apparently not a priority of those who have authored this bill because all that is contained in the bill is a nonbinding sense of the Senate. We have heard that medical liability reform laws, such as those that have been passed and implemented in Texas—if passed nationwide, this bill could bend the cost curve by $54 billion over 10 years. Yet all we get is a watered-down sense of the Senate that has no binding effect at all.

If the President was sincere about making those promises to the American people, then this Congress ought to be sincere about helping him keep that promise. The fact is, time after time, this bill breaks the promises that President Obama made to the American people. It is not too late to change that. I hope that, today, when he meets with Senate Democrats behind closed doors, to the exclusion of Republicans, there will be some discussion of how can we help you keep those promises to the American people because this bill does not.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I yield such time as they need to several Senators for the purpose of a colloquy.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, I am pleased to see my friends on the floor again today—very intelligent people, such as the Senator from New Hampshire and my friend, Senator ENZI, who is an expert on this issue, and the rest of us who know that a fight not joined is a fight not enjoyed. I look forward to another spirited discussion with my colleagues.

Maybe if I could, to start with, I will take up a point about the debate and discussion we had yesterday on the floor with the Senator from Montana, the chairman of the committee, where he asked me why did I think that certain groups supported this legislation pending before the Senate. I said I didn't know what kinds of deals had been cut. I referred to the deal made with PhRMA and others. I didn't know exactly why because I am not taken into the discussions and negotiations off the floor in the office of the majority leader.

There seems to have been some blowback on that, and somebody said maybe that wasn't appropriate to talk about deals that were cut. This morning, on the front page of the Washington Post, it says:

Deals Cut with Health Groups May Be at Peril.

Perhaps the Washington Post is impugning the reputation of someone or staffers or others. They have certainly impugned mine from time to time. But the fact is, this is a news story.

Again, I go back, very briefly, because we have a lot to talk about, my colleagues and I. The fact is, there have been deals cut, just like is reported in the Washington Post this morning, as has been reported all over America about the deals cut with various interest groups that don't necessarily represent the people they claim to represent. I know the American Medical Association does not represent the majority of physicians and caregivers. In the State of Arizona, I know too many of them. I also know they have a very large lobbying presence in our Nation's Capitol, as do the other interested groups that have ''cut deals'' that may be at peril now, according to the Washington Post.

With that, I will mention, again, that the doctor is in. Would the doctor care to give us some enlightened information, before we give our various opinions on this issue?

Mr. BARRASSO. I agree with the Senator from Arizona. I looked at another one of his favorite newspapers, the New York Times, today because we—

Mr. MCCAIN. My absolute favorite.

Mr. BARRASSO. On this floor have said the Democratic proposal is cutting the Medicare the seniors of this country depend on for their health care. We pointed out that they have taken $120 billion away from Medicare Advantage. Mr. President, 11 million seniors use Medicare Advantage. One out of four seniors is on Medicare. The reason they signed up for Medicare Advantage is because there is an advantage for the seniors—preventive care, coordinated care, things we know are important.

Yesterday on this floor, the Democrats voted to cut away from home health care. This is a lifeline for homebound patients. It helps keep them out of the hospital and out of the nursing homes. Yet in spite of all the letters we have read from patients, as well as home health care communities in all of our States, they have cut back.

Yet the majority whip came to the floor at the opening of the session today and said: Oh, we have handled all of that. He said: We have handled all of that with a wonderful resolution of the Senate by Senator MICHAEL BENNET.

The New York Times today, about that resolution, said:

Democrats decided to respond to the Republicans saying: Hey, you are cutting Medicare for our seniors. ''Democrats decided to respond . . . with a meaningless amendment.'' The New York Times editorial today, ''a meaningless amendment.'' We knew it was meaningless, and we know they are cutting Medicare from the seniors who depend on it—Medicare Advantage from hospitals, from nursing homes, from hospice, from home health care. This is robbing the people who need this care, deserve the care.

If you said maybe we should take a look at Medicare, then do it, Mr. President, to save Medicare, to save Medicare that we know is going broke.

I see the Senator from New Hampshire is here. He has been an expert on this topic of the budget and ways we can save Medicare. I say to my friend from New Hampshire, is this not true that Democrats have proposed a meaningless amendment but they are cutting the guts out of the Medicare Program on which the seniors of this country are dependent?

Mr. GREGG. As usual, the Senator from Wyoming is absolutely true. The sense-of-the-Senate amendments we have had from the other side of the aisle on Medicare are political amendments meant to make a political statement, but they have no substantive effect. That is why I brought forward my amendment which hopefully will be voted on in the next couple of days or so which says specifically what the Senator from Wyoming has asked for.

To the extent there are reductions in Medicare spending—and there may need to be some—that those reductions are reserved for the seniors for the benefit of their program and to make Medicare more solvent and no new programs be created on the backs of seniors by cutting Medicare and moving the money from Medicare over to new programs.

My amendment is not a sense of the Senate. My amendment is a real amendment. It is the one chance people are going to have to vote for protecting Medicare and not creating new programs with Medicare money. And that is what it is going to be.

Mr. MCCAIN. To be clear, the amendment of the Senator from New Hampshire is exactly the same as the White House sense-of-the-Senate amendment and the Bennet amendment, only it has the actual force of law.

Mr. GREGG. Absolutely. It is not exactly the same in the sense that it is real. Theirs is not real. Mine is real. It says you are going to keep the Medicare money to benefit Medicare, and you are not going to use the Medicare money for the purpose of creating new programs which have nothing to do with Medicare for people who are not on Medicare.

Mr. ENSIGN. I say to the Senator from Arizona, another place in this bill where they have a sense of the Senate that is not real is medical liability reform. Back in September, when The President addressed the Nation, he said

defensive medicine caused by the medical liability crisis may be contributing to unnecessary costs; there are unnecessary tests.

Let me show you the amount of money they are going to save with their medical liability reform sense of the Senate in this bill. That is it. That is how much their sense of the Senate on medical liability reform is going to save—zero.

In contrast, the Medical liability reform several of us have offered is real medical liability reform. Several of us have been working on that. The savings from a real medical liability reform: $100 billion.

We at least have said we have an amendment we are going to vote on later today. Let's at least do something to get the ball rolling on medical liability reform with the amendment we are offering today. The President suggested getting the ball rolling on medical liability reform.

Back in 1995, Senator Ted Kennedy offered an amendment that would at least limit attorney's fees. These are contingencies fees. Twenty-one Democrats who were here back in 1995 who are here now voted for that limit. They are: AKAKA, BAUCUS, BINGAMAN, BOXER, BYRD, CONRAD, DODD, DORGAN, FEINGOLD, FEINSTEIN, HARKIN, INOUYE, KERRY, KOHL, LAUTENBERG, LEAHY, LEVIN, MIKULSKI, MURRAY, REID, and SPECTER. All 21 of these Senators voted for caps on attorney's fees. That would at least do something. That would help get the ball rolling on medical liability reform.

But the same thing they have done with Medicare, saying they are going to keep Medicare savings in Medicare, they have not done. It is not real. Senator GREGG has a real amendment to fix that. I have a real amendment to fix the medical liability reform that hopefully will be voted on later as well. But at least let's go for a little bit of compromise right now.

Mrs. HUTCHISON. Will the Senator from Nevada yield?

Mr. ENSIGN. I will be happy to yield.

Mrs. HUTCHISON. Talk about liability, I have real statistics. I hear the other side say: Oh, we are going to lower the cost; that is what health care reform is about, lowering the cost of health care so more people will have access to affordable options. Yet the main one that is clearly available is medical malpractice reform, tort reform.

I know the Senator from Nevada has an amendment, and I am a cosponsor. Let me give some statistics about how we could save money.

Mr. MCCAIN. May I ask the Senator from Texas, is it not true that it is the State of Texas that is the demonstration project for medical malpractice reform?

Mrs. HUTCHISON. Exactly. And let me tell you what it has done in Texas and something we could do, and I think we would have bipartisan, 100 percent support in this body because that would be reform that would help health care.

Since medical malpractice and tort reform has been passed in Texas, over 7,000 new physicians have flooded into our State—a 7,000 increase. The reason? Tort reform. Since passed just 5, 6 years ago, physicians in Texas have saved $574 million in liability premiums, and their liability rates have been cut an average of 27.6 percent, almost a 30-percent cut in premiums.

What has this done? Today in rural counties, the number of obstetricians has increased by 27 percent. Twelve counties did not have one obstetrician before this was passed, and now they do; 24 counties had no emergency room physicians, and now they do; and 58 counties, in addition to that, have added one more.

Rural counties are the ones that have suffered the most, and every State in this Union has rural counties—every one. They are the ones who are hurt the most. Yet the Medicare cuts will take $135 billion out of rural hospitals' ability to serve Medicare patients. There is no medical malpractice reform unless, of course, in a huge bipartisan effort and gesture we can adopt the Ensign amendment which we are offering to try to make this a bipartisan bill that can work.

We have seen from Senator ENSIGN's charts that Democrats have supported limits on lawyer fees so that we would be able to cut back on the frivolous lawsuits that have been hampering our ability to cut the costs in Medicare.

I appreciate so much that Senator ENSIGN is offering this amendment because Texas can show us that this will work. It would be meaningful reform. It would cut the costs and make health care more available and, most important, it will give patients the opportunity to have doctors in their rural communities who will not practice today because their liability premiums are so high they cannot afford to stay in medicine and give this care to those rural patients. That is what we need.

Mr. MCCAIN. May I say in the immortal words of Howard Dean, the former chairman of the Democratic National Committee—he put it simply:

> The reason why tort reform is not in the bill—

Talking about this bill—

> The reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the plain and simple truth. Now, that's the truth.

I totally agree with Howard Dean. I could not agree with him more.

Mrs. HUTCHISON. If the Senator will yield, in addition to that, the House said: We have medical malpractice reform. They put it in their bill. You know what it says? There will be a State grant program and States can apply if they can show that they have made a meaningful effort at curbing frivolous lawsuits. But the only two reasons a State would not be eligible are if lawyer fees are capped or if damages are capped. Lawyer fees capped, damages capped—that is off the table. So I am thinking to myself—maybe the Senator from Nevada could tell me, if you don't curb lawyer fees and you don't curb the caps, what meaningful reform do you think we could get in medical malpractice?

Mr. ENSIGN. No question, those are the two most important types of reforms for medical liability laws that have been placed in the States—my State of Nevada, Texas, California and other States. The caps are what have shown a reduction in the medical liability premiums for doctors. They are what have shown a reduction in the cost of our health care system.

Mr. President, let me quote because the other side is talking about these contingency fees; that they need these contingency fees to take on these lawsuits, especially for those who are very poor. They say it is the only way for this to happen.

I quote:

> Since 1960, the effective hourly rates of tort lawyers—

These are the personal injury attorneys—

> have increased 1,000 percent to 1,400 percent (in inflation-adjusted dollars).
>
> While the overall risk of nonrecovery has remained essentially constant though it has decreased materially for such high end tort categories as products liability and medical malpractice.

The lawyers, basically, have created all these laws that make it easier for them to sue and their contingency rates have gone up 1,000 to 1,400 percent since 1960, and yet there is no more increased risk and even reduced risk of nonrecovery in medical malpractice cases. It is easier to sue nowadays. This comes down to, are you on the patients' side or the trial lawyers' side? Which side are you on? We are on the side of the patients; the other side seems to be on the side of the trial bar.

Mr. MCCAIN. The Senator from Alabama.

Mr. SESSIONS. I thank the Senator from Arizona for driving home this point. The reason that malpractice litigation reform is not in the bill is simple, plain, and known to every Member of this body because it is opposed by the plaintiff trial lawyers who are big supporters of Democratic Members of the body and the President. That is true.

Let me ask Dr. BARRASSO, can the Senator think of any other thing that we could do in reforming health care that could save $100 billion and not diminish the quality of care in America? Is there anything else? How do fellow doctors feel about that?

Mr. BARRASSO. When I talk to other doctors, they tell me, across the board they order a number of tests, expensive tests—call it defensive medicine—tests that do not necessarily help a patient get better, get well, but just to make sure they get covered in case they are sued. It is not unusual, when

you look at the numbers, that we are talking $100 billion a year in tests that are done that do not necessarily help somebody get better, but they are doing it because of the legal atmosphere in this country.

Here we are on the Senate floor on a Sunday afternoon. The President is less than 100 yards away, a former Member of this body. He ought to be involving all Senators. He is meeting behind closed doors, possibly cutting deals, trying to come to arrangements, twisting arms, asking people to march, follow his marching orders right off a cliff that I think is going to be coming for health care in America. I think he ought to be involving all Americans. We are talking to the Americans in this country. We are not hiding behind closed doors. People who aren't part of those discussions are completely cut out.

I know my colleague from Tennessee has been outstanding and outspoken on these very issues, but we are here, and we want to visit with people because we do have solutions that work; that will not increase the cost of care, which is what we are seeing now; that are not going to cut Medicare, which is what the Democrats are proposing; that are not going to increase taxes, which the Democrats are proposing; and they are not going to drive up the premiums.

The whole idea behind this was to get the costs under control. Senator ENSIGN's amendment does that by taking a look at the lawsuit abuse that we look at in this country. But I want to turn to my colleague from Tennessee, who I know has some more points he wants to make.

Mr. CORKER. I know all of us benefit from the Senator's background as a physician and knowledge in the industry. I also thank the Senator from Arizona for spending a lifetime focusing on how special interests affect this body.

I was thinking about this meeting taking place here in the Capitol not far from us from 2 to 3 p.m. with the President and 60 of our colleagues on the left, and I have this image of them being twisted up like pretzels because of the fact there are so many interest groups they have to sort of kowtow to. I have this image of a bunch of them up in a room with a yoga instructor, kind of loosening up, because they are so twisted in knots trying to basically undo all the pledges they have made to so many groups.

I think about, for instance, Senator ENSIGN's amendment to deal with medical malpractice, but, no, the trial lawyers keep them from doing that. I think about the kinds of things Senator MCCAIN ran on during his Presidential election campaign, and others of us have looked at, as has Senator GREGG, so that people in this country have choice; that we create a market system that allows people to have choice. But they cannot do that because the unions don't want them to do so. The unions don't allow them to cap the exclusion, which many of us have talked about. The unions keep them from doing appropriate health care reform, and so instead, what happens, in order to make this work? Again, they are so twisted up. Remember that Peter Orszag, the major guru within this administration regarding health care, has said the thing that will bend the cost curve down would be these exclusions. I am so glad Senator GREGG, who has the integrity and the longstanding knowledge to deal with this, is offering an amendment.

Yesterday I was challenged on this by Senators on the other side of the aisle, but there is no doubt this bill throws seniors under the bus. We have an insolvent program that money is being taken from to create a whole new entitlement it is leveraging. If that is not throwing seniors under the bus, I don't know what is. So we have a program that is throwing seniors under the bus because the unions cannot be offended, the trial lawyers cannot be offended, so many other groups—AARP cannot be offended—and then we also lock 15 of the 31 million Americans who are receiving health care into a program none of us would be a part of—Medicaid. And they do that because of their unwillingness to address the free market issues that would make health care work in this country: medical malpractice issues, addressing defensive medicine, capping exclusions, and those kinds of things we Republicans have put forth from day one.

So I think the Senator from Arizona is doing an outstanding job pointing out the conflicts of interest that exist in this bill. We have a group on the other side of the aisle that won't address health care in the appropriate way, and I believe are in another room twisted up in knots with themselves trying to figure out a way to get out of this box they have put themselves into, and a President who is basically giving them a pep talk to keep them from getting out of the box.

I thank the Senator so much.

Mr. MCCAIN. Our Republican leader is here on the floor of the Senate, and he can speak for himself, but I am sure he would appreciate the opportunity if the President would come and sit down and meet with us. I think we are all ready to have a meeting with him. Perhaps we would be able to give our input and recommendations as to what we need to do to get this bill unstuck.

That was, as I recall, the campaign. And I am getting tired of going down memory lane here, but that was going to be the ''change.'' That was going to be the change in Washington. We are going to change the climate. We are all going to sit down together, Republicans and Democrats. Well, I think on this Sunday afternoon, we are all available, are we not, I would ask the Senator from Kentucky?

Mr. MCCONNELL. I would say to my friend from Arizona, normally we would be watching the Redskins game today, but we are here and ready to sit down with the President and ready to discuss with the American people this issue.

You know, it was said at the beginning of the debate, if they wanted to come up with a bill that would pass with 80 votes, the way to do that is not to craft a bill that no Republican can support and end up in the position they are in now, trying to get every single Democrat in line so they can pass this bill, even though they know the American people are overwhelmingly opposed to it. All the surveys indicate the American people do not want us to pass this bill. They would like for us to stop, start over, and get it right, with some of the suggestions that have been made here on the floor today and other days during this debate.

Mr. MCCAIN. And we could do that, perhaps in the most effective fashion, if we sat down with the President and made some of the very points he made in his State of the Union Message.

I want to turn to the Senator from South Dakota, but I want to mention something first on this issue of tort reform I have never quite gotten over. One of the most famous cases of the 1970s, and I think it spilled over into the 1980s, was agent orange, the defoliant that was used during the Vietnam war and which caused so many physical problems for our Vietnam veterans who were exposed to it. It was a big class action suit the trial lawyers won. The trial lawyers got paid off first, and Vietnam veterans died before the money was distributed to them. I will never get over that.

Mr. THUNE. I think the reason we are here today is that the Ensign and Gregg amendments strike at the very crux and the very core and the very heart of what this is all about. The Democratic majority was unwilling to take on the trial lawyers, unwilling to do things that actually bend the cost curve down, such as capping contingency fees, and so now we are faced with voting on the Ensign amendment, which would do that, but we are also voting on the Gregg amendment because they weren't willing to put actual measures in this bill that would bend the cost curve down. What they have had to resort to is cutting Medicare to pay for it. A $2.5 trillion expansion of the Federal Government has to be financed somehow, because there aren't any real cost-saving measures in here.

I point out to my colleagues that in spite of all that, this is where we are. The Congressional Budget Office says that even with the all of the Medicare cuts and all the tax increases that are in here, we actually still increase spending in this country on health care. The cost curve goes up. The blue line on this chart represents the existing cost curve if nothing is done. If we did nothing today, that is what would happen. That is the blue line. The red line represents what happens under this bill. We actually raise the cost

curve even more. Costs for health care in this country under this legislation go up $160 billion.

How does that affect the individual family? I want to show you exactly what this means in terms that I think most Americans can understand. This is the example of a family of four who today is paying $13,000, a little over $13,000 for their health insurance. Under this bill, their life doesn't get any better. In the year 2016, they are going to be paying over $20,000 a year in health insurance. So what happens is they have locked in the status quo. And that status quo is year over year increases, double the rate of inflation, all because they were unwilling to put measures in this bill that actually do control costs.

If we did something along the lines of the Ensign amendment, that actually would get these contingency fees under control. We all have seen the statistics. The CBO has said that would bend the cost curve down.

We have all talked to physicians in our own States. I talked last week to a physician from my State who, unsolicited, said that 50 percent of the tests he does are to avoid being sued. Fifty percent of the tests he conducts are due to defensive medicine. That drives the cost of health care up for everybody. That is why the Ensign amendment is so important.

Unfortunately, why we have to vote on the Gregg amendment is because the Gregg amendment forces the Democrats to put their money where their mouth is and to see if they mean what they say—that they want all these savings in Medicare to go into Medicare. We all know that is not true. To pay for a $2.5 trillion expansion of the Federal Government and create an entirely new entitlement, you have to take the cuts from Medicare and put them into this new entitlement program.

So we are voting on a couple of amendments today that will ensure seniors in this country are not going to be faced with cuts to their benefits—home health care, nursing homes, hospitals, all those that receive cuts in this bill—and actually try to substitute something in there that would get costs under control, and would—according to the CBO—drive the cost curve down; would do something about this year over year double the rate of inflation that the average American family is seeing.

This is what the CBO said would happen to the average American family of four if this bill passes. Today they are paying $13,000 a year—a family of four—and in the year 2016, they will be paying $20,000 a year. Tell me, how is that reform? How can anybody go to an average American family with a straight face and say they are reforming health care when all they are doing is locking in permanently year-over-year increases that are double the rate of inflation, and in some cases even going up beyond that if you have to buy your insurance in the individual market?

I am glad the Senator from Nevada has offered this amendment. I am anxious to see how the other side votes on the amendment the Senator from New Hampshire has offered which would guarantee these Medicare savings would go back into Medicare and not be used to pay for a new government entitlement program at a cost of $2.5 trillion to the American taxpayer.

Mr. McCAIN. I will recognize the Senator from Texas, who will be presiding next, and wish to add one more comment.

Mrs. HUTCHISON. I so appreciate the opportunity to talk about these different areas of cuts and then the increase in spending overall, because everyone in America today is concerned about the spending and the debt and the ceiling we are about to reach.

I wanted to bring up one more point on hospitals, because this affects every State in America. In Texas, 29 percent of our hospitals are in rural areas. The cuts in this bill will especially affect hospitals in rural areas. In fact, out of the $135 billion in Medicare cuts to hospitals, $20 billion is cuts in Medicare payments for treating low-income seniors and another $23 billion in Medicaid payments to hospitals for treating low-income patients.

I want to read an excerpt of a letter I received this week from the Texas Organization of Rural and Community Hospitals, which represents 150 rural hospitals in the State. They write:

> We also fear the Medicare cuts as proposed could disproportionately hurt rural hospitals, which are the health care safety net for more than 2 million rural Texans. Because of lower financial margins and higher percentage of Medicare patients, rural hospitals will be impacted more than urban hospitals by any reductions in reimbursement. These proposed Medicare cuts could have a devastating effect on many of the hospitals, which could lead to curtailing of certain services. And, the closure of some of these Texas hospitals is a real possibility. It has happened every time previously when Congress imposed so-called large-scale, cost-saving measures.

Well, this is the granddaddy of large-scale cost cuts—$500 billion, or ½ trillion—taken out of the hide of the hospitals that are treating low-income patients and seniors.

I ask the Senator from Nevada if he is experiencing that same thing, and if he feels that hospitals all over our country are going to be hurt by this bill?

Mr. ENSIGN. Mr. President, I thank the Senator from Texas for her comments, and I note that even the Congressional Budget Office has said when you cut, for instance, reimbursement rates, those are going to come out of somebody's hide. And basically, the hide it is going to come out of is the seniors.

As the Senator from Tennessee said, we are throwing seniors under the bus. When you cut $465 billion out of Medicare, it is going to come out of services for seniors—if these cuts are real. And in this bill they are real. That is why the Gregg amendment is going to be so important.

I know the Senator from Kansas wants to jump in, so we welcome you to the conversation.

Mr. BROWNBACK. I appreciate that. I also note the Ensign amendment, instead of cutting, creates.

A Robert Woods study in 2006 said caps on things such as this hold down awards in cases 20 to 30 percent and increases the supply of physicians, which is something else we need.

I wish to give a better live example that we have in my State of Kansas. In the early 1980s, mid-1980s the piston engine industry of aircraft was just about dead. It had been sued—the aircraft industry, general aviation had been sued so much they were stopping making piston engine aircraft. Congress, finally, because the industry was dead, said we are going to put a 17-year statute of limitations on it so after 17 years you cannot sue the manufacturer anymore after that period of time.

It brought the industry back. They are now being made. There is a new plant in Independence, KS. There is another one that is making this aircraft because there was a limitation put, a reasonable limitation on manufacturing reform.

If we do this, this will create—this will help our medical industry, it will hold down costs, it will increase the number of physicians. These sorts of changes have worked. There is no reason at all not to do this in this bill.

Mr. ENSIGN. I thank the Senator from Kansas for his excellent remarks. I know the Senator from Florida, the newest Member, one of the newest Members of the body, would like to join in.

Mr. LEMIEUX. I thank the Senator from Nevada.

I don't know that there is a State that is going to be more impacted by cuts in health care for seniors than my State of Florida, with 3 million Floridians on Medicare, almost 1 million on Medicare Advantage. I think it is worth repeating what these cuts are going to mean: $137.5 billion from hospitals that treat seniors. I talked to the director of a hospital district down where I am from, down in south Florida. He said these cuts will be devastating: $120 billion from Medicare Advantage, $14.6 billion from nursing homes that treat seniors, $42 billion from health care for seniors—from home health care, and $7.7 billion from hospice care.

Yesterday, our friends on the other side were trying to convince us and the American people that there are not going to be any cuts to benefits. It is not going to affect health care for seniors because they are going to pay less, but that will just get rid of the waste and the fraud and the abuse.

Everyone is against waste fraud and abuse. We have a measure on this side of the aisle that actually, I think, would do something about it. We have gone through the Reid bill to find all

the provisions. My staff and I have been going through it, line by line, to find all the provisions that go after waste, fraud, and abuse—and there are some, to their credit. But the Congressional Budget Office has said, in their report that came out on November 18, the provisions that go toward waste, fraud, and abuse would cut $1.5 billion and create that efficiency. But the cuts are $464 billion. So if they are going to save $1.5 billion and there is going to be $464 billion in cuts, where are the rest of the cuts going to come from?

It is, as my friend, the Senator from Tennessee, said, seniors are going to get thrown under the bus. But you are not going to be able to cut $464 billion, only get $1.5 billion in savings, and not cut benefits. So seniors who want to go to the hospital are going to have their benefits cut; seniors who have home health care, their benefits are going to get cut and all the way down the line. Everyone needs to understand that at its base, this is a bill that hurts seniors.

Perhaps no State is going to be impacted more than Florida, where we have this huge population of seniors. I know my friend from Nevada has a huge population of seniors in his State. We have the highest per capita number of seniors. We like to say all the rest of the seniors in the country are eventually going to move to Florida anyway. We are going to have the greatest generation—we have them there now—we are going to have more of them living in Florida, and their health care is going to get cut.

This bill cuts from health care for seniors, it raises taxes, and it doesn't decrease the cost of health care for the 170 million Americans who have health insurance now. For some, it raises it.

For me, a new Member to this body, it does not make any sense. But what does make sense is what my esteemed colleague from New Hampshire has done with this amendment. If you are for health care for seniors and you do not want it to be cut and if you are true to your word that we have to put the savings back into Medicare, then this bill, which says as its purpose ''to prevent Medicare from being raided for new entitlements and to use Medicare savings to save Medicare''—I cannot imagine that anyone could vote against that amendment, because if you vote against that amendment, you are voting against senior health care.

I ask my colleague from New Hampshire, who has so much experience on these budget issues, if this amendment is not agreed to, what is going to happen to the Medicare program?

Mr. GREGG. To begin with, it is going to be reduced by $460 billion in the first 10 years. In the second 10 years, it will be reduced by $1 trillion. In the full 20-year time, it will be reduced by $3 trillion. All those funds, all those reductions, will go to create a new entitlement for people who are not seniors and who probably have not paid into the HI trust fund, not having paid into the Medicare trust fund, which is an insurance program, in part.

As a practical matter, it will take scarce resources out of the Medicare trust fund, which should be used to make the Medicare trust fund more solvent, and move them over to expand the Government in another place.

It will mean that we as a government have basically used up some of the resources which we might want to use to make Medicare more solvent because it has $35 trillion of unfunded liability out there, and we will use up those resources to create a new Federal program which will not help us address this outyear insolvency of Medicare.

It doubles the problem. First, it does not address the Medicare problems in the future and, second, it creates a brandnew entitlement which will have to be supported forever by Medicare funds, it appears.

Mr. ENSIGN. I see the Republican whip is on the floor and wants to join in the fun we are having on a Sunday afternoon. Please join us.

(Mrs. HUTCHISON assumed the chair.)

Mr. KYL. I thank my colleague from Nevada. I had the opportunity, which we don't have very much anymore, to preside for a half hour, watching over a dozen of my Republican colleagues engaging in a very informative debate for the American people.

It occurred to me, as my colleague from Nevada was talking about his amendment, which would actually reduce the cost of medicine, would reduce the defensive medicine practiced by physicians and, therefore, have a tendency to reduce health care costs, that he was doing that by actually attacking another problem we have been talking about; that is, these runaway lawsuits or these junk lawsuits that have been talked about.

As a person who used to practice law, as I was listening to the Senator, it occurred to me that maybe I should take the microphone and defend the trial lawyers. So I wish to make sure I have the math right.

Under the amendment of my colleague, there would be a cap on the amount of attorney's fees these lawyers could get, depending upon how much money they recovered for their plaintiff client; is that correct?

Mr. ENSIGN. That is correct.

Mr. KYL. First of all, you would get one-third of all the money you collected up to $150,000. That is $50,000. Then you would get one-fourth of everything beyond that; is that correct?

Mr. ENSIGN. My colleague is correct.

Mr. KYL. Is my colleague aware that the average malpractice award in this country today is $4.3 million? Does that sound about right?

Mr. ENSIGN. It depends on the State, but that sounds about right.

Mr. KYL. In fact, over half of all the awards are over $1 million. As a poor trial lawyer, for every one of these cases—we are not talking about cases per year and this is per case, you can try 20, 30, 40, 50 cases a year—so for each case, if the average award is $4.3 million, I am only going to keep $1.1 million. Is that fair; that the trial lawyer should only get $1.1 million for every one of these cases? Of course, the clients I am recovering the money for don't get that money. That money goes into my pocket.

Mr. ENSIGN. Remember, if I would ask a practicing attorney, they also don't just get that percentage, they also get court costs and various other research they have to do. It is not that the person who was injured gets three-quarters; they actually get less than the three-quarters that even this amendment would limit them to.

Mr. KYL. Exactly so. Under the amendment of my colleague, at least the plaintiff, on whose behalf the lawsuit was brought, would get a fair amount of recovery, unlike today, when there are no caps, and we frequently find the person who was injured gets a very small percentage after the lawyer gets his chunk, the expert witnesses, other court costs, and so on.

Maybe I should not defend my lawyer friends. Maybe the Senator is right. This is a way to attack costs. It is certainly not unfair to the trial lawyers and actually would benefit the people who do deserve to get some recovery in these cases where, in fact, they have been injured.

Mr. ENSIGN. We do have a couple attorneys on the floor, including the ranking member of the Judiciary Committee, and maybe one of the two of you could also talk about the true victims who actually have had medical malpractice against them. How long does it take to get through the court today because of all of these frivolous lawsuits that clog the courts?

Mr. SESSIONS. I think the Senator raises a very important point. It seems to me that there should be mechanisms created to settle cases much quicker, without the huge payouts going to lawyer fees and litigation. Don't forget, the insurance company that the doctor hires and that is defending the doctor charges too. That is all money going to increase the cost of health care.

I have with me, today, working for me, Dr. Conrad Pierce. On a normal day in Alabama, he would be my Sunday school teacher today. Today he is working.

He just retired. He delivered 7,000 babies. He told me, some years ago, that an average OB's insurance for a year is $60,000. I don't know whether it is still that way. That was several years ago. Some smaller town physicians may not deliver more than 60 babies a year. That is $1,000 per delivery in insurance premiums. It is driven by this litigation rush we are having, and the pursuit of these big verdicts that sometimes occur and make lawyers wealthy—and, to be fair, sometimes serious injuries occur and serious malpractice occurs. But I absolutely believe this country can, consistent with

our heritage of allowing individuals to sue for wrongs done to them, create a much better system for medical malpractice. One of the steps is the one the Senator has mentioned in his amendment.

Mr. ENSIGN. I appreciate that. Maybe we can have Dr. BARRASSO jump in. I have a good friend who practices obstetrics and gynecology in Las Vegas, and he is a specialist in high-risk pregnancies. Because of the messed up medical liability situation, his insurance company limited the number—the same as Senator SESSIONS was talking about—limited the number of high-risk deliveries he could participate in. So if you are one of the unfortunate ones who got cut off—in other words, he had reached his cap of the number he could actually deliver, and you are a woman who has a high-risk pregnancy—there may not be one of the specialists around. Now you have to deal with just the normal OB who may not have the expertise.

What does that do to not only the practice of obstetrics but, as an orthopedic surgeon, I am sure this kind of example plays out in many other areas in medicine?

Mr. BARRASSO. Standing on the Senate floor, looking at so many colleagues from States with a lot of rural areas, it is a challenge to have people who can provide these excellent services, who are very well trained, know how to do it, how they can provide the services in these small communities. We have dealt with that in Wheatland, WY, and New Castle, WY, where the expense for the malpractice insurance for those physicians was so high that even though they didn't deliver that many babies in these small communities, they could not afford and the hospital could not afford to allow them to continue to deliver any babies. The amount of money they would receive from delivering babies was not enough to cover the insurance. In New Castle, WY, there were three physicians qualified to deliver, but the number of deliveries was such they ended up with no one delivering because they wanted to take one night and the next and the next. So you have communities all across our country that are losing highly qualified medical practitioners—whether it is cardiologists, surgeons, trauma surgeons, whether it is obstetricians, gynecologist. We are seeing this all over our communities.

The Senator from Tennessee is here. There are a lot of small communities where they are going to lose those. We are seeing it in the cuts yesterday for home health. Those people are not going to be available to deliver small community care, lifeline, homebound, keeping them out of nursing homes, keeping them out of hospitals.

There are real consequences of this bill, not just with the junk lawsuits—that is a big part of it—but also with the Medicare cuts, also with the increased taxes we are seeing in this bill and how that is going to affect small businesses, which are the engines that drive the economy of this country—and profoundly.

We heard the Senator from South Dakota show the premiums families are going to have to pay for insurance are going to climb faster if this bill becomes law than if nothing were passed. Even though the President promised that families in this country on average would see a $2,500-per-year decline in premiums, the President's own numbers people say: Sorry, it is going to go up $2,100. That is a $4,600 shift for every family who tries to buy their own health insurance. That is what we are seeing in Wyoming.

I ask my colleague from Tennessee if he is seeing the same things at home.

Mr. CORKER. Madam President, I have just finished my second tour of all 95 counties in our State. In 91 of the 95 counties in our State, women do not have access to the types of medical services they should have. The reason is that this whole issue of malpractice is especially prevalent in the issue of OB. That is the area of babies being born. Obviously, a physician cannot determine if there is going to be a genetic deficiency of some kind or something else. But trial lawyers are out there waiting to ensure that no matter what happens, even if it is by the grace of God that something happens that is not so good, the fact is a trial lawyer is waiting there to take advantage of a physician. So they have just decided to leave that particular industry.

We have had a bunch of side-by-side votes here. The American people understand the trickery that takes place. Fortunately, Senator MCCAIN's favorite publication, the New York Times, pointed out what absurdity it was yesterday that we passed 100 to zip the Bennett amendment which everybody knows is toothless.

Today, we have the opportunity to actually have a values vote. The American people can determine the values of each Senator. Senator ENSIGN has an amendment to cap the amount trial lawyers are paid. Senator LINCOLN has one to cap the amount that people who are actually delivering health insurance are paid. This is a values vote. We have a nonprofit in our State that pours every bit of its money back into providing health insurance. Senator LINCOLN's amendment would cap the amount that person is paid. Senator ENSIGN would cap the amount a trial lawyer is paid who is pursuing a physician and causing them to pay more. This is the first of a real values vote.

Mr. ENSIGN. One clarification: We don't cap the total dollar they can be paid; we just cap the percentage. So even though they will cap at $400,000 what somebody can be paid for an insurance company, trial lawyers could still, because they can get up to 25 percent of the verdict—if the verdict is on average, as we learned from Senator KYL, $4 million, they can still make $1 million on that one case, and they can have however many of those cases they want per year.

Mr. CORKER. I know Senator ENZI wants the floor.

Mr. GRASSLEY. Madam President, there are a number of issues that this amendment raises. Some are health care-related, most are not.

First, this amendment amends section 162(m) of the Tax Code—a tax law intended to curb excessive executive compensation.

Unfortunately, section 162(m) has been a disaster. It has encouraged companies to cook up complex design packages so as to avoid the limitations under the law.

Actually, excessive executive compensation exploded as a direct result of section 162(m)—which was enacted back in 1993.

I have consistently made it clear that the outrageous pay practices of many companies must stop. True pay-for-performance must be the cornerstone of any compensation package. And the boards of directors, compensation committees, and shareholders must all be partners in practicing good corporate governance. We should look to reform section 162(m) of the Tax Code, not add to it. And we should look at whether Congress needs to reform the way corporate governance is practiced.

This amendment adds to section 162(m). It does not reform it. This amendment does nothing to empower shareholders to hold the corporation's board accountable. All it does is hurt shareholders by taking money out of the company and giving it to the government.

That is right. By limiting a corporation's deduction, shareholders are the ones who are disadvantaged, not the corporation.

My friends on the other side of the aisle forget that seniors are often shareholders who rely on dividends and capital gains for income to live on day in and day out. So actually, my Democratic friends are enacting policies that will hurt seniors. All in an effort to show the country that they have it in for the big, bad insurance companies.

I also find it interesting to hear my friends say that it is unfair for insurance companies to get a taxpayer funded "subsidy" in the form of a tax deduction.

First, all corporations are allowed to deduct compensation as a business expense. Big, small, private, and public corporations get this same tax deduction.

Are these companies getting a tax subsidy? If so, why not take the subsidy away from them?

Now, my friends on the other side may argue that these restrictions are just like those Congress passed in T-A-R-P. And the way the legislation works, they would be correct.

But, the executive compensation restrictions in T-A-R-P were conditions for receiving taxpayer dollars. My constituents in Iowa would call them bailouts.

Now my friends may argue that health insurance companies are benefiting from their reforms and they should pay their ''fair share.'' They may also say that they are receiving the government-subsidized tax credits for health insurance, which is taxpayer dollars.

The main reason why the government is subsidizing health insurance for low-income individuals is because the Reid bill forces people to buy health insurance.

If you force people to buy insurance, you have to make sure it is affordable for them to buy. This has forced the government to spend close to $400 billion on these tax credits, which is one of most expensive parts of the Reid bill. And the cost of these tax credits are paid with higher taxes, fees, and penalties on the majority of Americans. Paid by many of those who earn less than $250,000 a year.

Data from the Joint Committee on Taxation tells us that 38 percent of tax returns making under $200,000 in 2019 will see a tax increase under the Reid bill. Yet only 8 percent of tax returns in 2019 will be benefiting from the tax credit. That doesn't seem balanced.

Finally, this amendment directs the revenue generated from it to the Medicare trust fund. I commend my Democratic friends for crafting policies that would help shore up Medicare. What is interesting is that this bill cuts Medicare. To the tune of $400 billion—that is billion with a B.

And the money raised from cutting Medicare is not being directed to help shore up Medicare. Rather, the money is being spent on expanding and creating new entitlement programs. The Joint Committee on Taxation scored this amendment as raising $651 million over 10 years—that is million with an M.

So what we have here is $400 billion in cuts in Medicare that is being used for other spending, in exchange for $600 million which would be directed Medicare trust fund. Doesn't seem like a fair trade.

Do my friends on the other side feel guilty for using Medicare money for non-Medicare purposes? And to make up for this guilt, they decided to direct non-Medicare-related money to the Medicare trust fund?

I will close by saying that my Democratic friends will take to the floor and say that anyone who votes against this amendment is ''in the pockets of the insurance companies.'' I will first tell my friends that they should look in the mirror. Then I will say opposing irrational policies that add complexity to our tax laws is not protecting insurance companies.

Let's get on to reforming our health care system, instead of voting on amendments so my Democratic friends can (1) look like they are taking it to the insurance companies, and so they can look like (2) they are helping Medicare solvency.

Mr. INHOFE. Madam President, I support the amendment offered by the Senator from Nevada, which I have also cosponsored, that calls for real reform of the medical liability system.

A key component to health care reform in our Nation is medical liability reform. However, the Democrats are not actually interested in making changes to the current system as evidenced by the inclusion in this bill of ''the sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance.'' Well that opportunity has come now, with a vote on this amendment that will limit the amount of contingency fees available to trial lawyers who bring medical liability actions.

The threat of massive lawsuits and the costs of insuring against them have driven doctors out of the practice of medicine, influenced doctors and nurses to avoid certain specialties, and in part led to the steady increase of health care premiums. With the threat of lawsuits hanging over their heads, doctors are forced to take extra precautions when diagnosing and treating patients through the ordering of additional tests and procedures. The Journal of the American Medical Association found that 93 percent of doctors admit practicing this type of self-protective medicine.

A recent study by the Pacific Research Institute estimates the cost of defensive medicine is at least $191 billion per year, while other reports put costs over $200 billion annually. According to the Congressional Budget Office, if Congress adopted only a few of the malpractice reforms we have seen various States enact, such as Texas and Alabama, the deficit would decrease by $54 billion over 10 years.

At the heart of this issue, beyond the costs and savings, is the damage the current liability system does to the relationship patients have with their doctors. When physicians are afraid they could be sued, not only do they run unnecessary tests and procedures, but the quality of care patients receive is compromised. A 2003 GAO report concluded that defensive medicine has also contributed to access issues, especially in rural areas. Physicians tend to move to States and areas with lower liability rates, and hospitals are able to expand available services.

It is estimated that attorneys' fees and administrative costs amount to 54 percent of the compensation paid to plaintiffs. Less than 15 cents of every dollar awarded actually goes towards compensation for the individual. This amendment is not about preventing compensation to injured individuals; it is about increasing access to doctors and lowering costs. In fact, this measure allows injured plaintiffs to keep more of the reward. The simple truth is that lowering the cost of doing business allows doctors to serve more people at lower costs.

On November 6, I received a letter from the Oklahoma State Medical Association, confirming that medical liability reform would reduce health care costs because the practice of defensive medicine adds billions of dollars to the yearly cost of health care. Oklahoma physicians pay anywhere from $20,000 to $90,000 a year, depending on their specialty, for malpractice insurance, and their yearly costs have risen astronomically since 1999 to the point that some specialties, like OB–GYNs, have had to change careers or move to other States where State malpractice reform is already in place. Since 1999, Oklahoma OB–GYNs have seen their yearly malpractice costs rise from $15,000 to $63,000.

Meaningful malpractice reform must be a part of any comprehensive health care reform. This is not a partisan issue. As my colleagues mentioned yesterday, this amendment was actually proposed by Senator Kennedy in 1995, with the support of many current Senators on the other side of the aisle. It will be very interesting to see just how serious the Democrats are about health care reform. The bill has a ''sense of the Senate'' recognizing medical malpractice costs are a problem. We will see if they think it is important to really do anything about it.

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

Mr. ENZI. Mr. President, the time for the colloquy has, unfortunately, expired. The balance of the time goes to the Senator from Iowa. I thank everybody for their participation.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I rise to speak in favor of the amendment of the Senator from New Hampshire.

Because as I have been saying, the people who wrote the excesses of the Reid bill appear willfully ignorant of what is going on in the rest of the economy outside of health care.

We are a nation facing very challenging economic times with industries in financial crisis and Federal debt increasing to all-time highs.

So we should be considering a bill that would create jobs and prevent this country from being burdened with a bigger and more unsustainable Federal budget instead of this health bill.

But instead, we are now considering a bill that cuts half a trillion dollars from the Medicare Program to fund yet another unsustainable health care entitlement program.

You have heard from Members on this side of the aisle about how flawed this approach is and how these drastic Medicare cuts will threaten beneficiary access to care.

Medicare's chief actuary at the U.S. Department of Health and Human Services has warned Congress in his report that these cuts could jeopardize access to health care for beneficiaries.

In fact, a number of Members on the other side of the aisle have made clear that they share our concerns when they joined us to vote in favor of motions to eliminate these cuts.

Most of the Members on the other side of the aisle, however, claim that this bill does no such thing.

They claim that Medicare money is not being used to start up yet another unsustainable entitlement program that we clearly can't afford.

They claim that the Reid bill doesn't technically change the law on guaranteed benefits for beneficiaries.

They are ignoring the fact that while those benefits may be technically guaranteed, if the cuts put health care providers out of business, then those guarantees will be nothing more than useless words in the Medicare Act.

Guaranteed benefits are not worth much without health care providers who can treat patients, provide home health services, run the hospitals and hospice agencies.

These claims are not good enough to assure seniors who have paid into the Medicare Program all these years. It is not good enough for protecting access to the health care services and benefits they were promised.

So the Gregg amendment would back up those claims with a real enforceable mechanism to ensure that Medicare savings aren't being used to fund a new program.

The Gregg amendment is needed to protect the Medicare Program.

After all, if you knew that the Medicare Program already had $37 trillion in unfunded obligations, would you be assured without an enforcement mechanism to back up those promises?

No guarantee is worth the paper it is written on without an enforcement mechanism to back it up. Otherwise, it is just a meaningless guarantee. It is not real without an enforcement mechanism.

The Gregg amendment provides that enforcement mechanism. It makes the guarantee real.

Opposition to the Gregg amendment will shine a light on the issue. If the Gregg amendment is not approved, it should be clear to everyone watching that all the guarantees they are making that Medicare is protected in the Reid bill are, in fact, worthless. As a result, I hope that everyone will be watching carefully how the other side votes on the Gregg amendment.

Now supporters of the Reid bill trumpet the fact that their drastic and permanent Medicare cuts extend the life of the program.

I agree that we can't ignore the pending insolvency of the Medicare Program.

The Medicare hospital insurance trust fund started going broke last year. In 2008, the Medicare Program began spending more out of this trust fund than it is taking in.

The Medicare trustees have been warning all of us for years that the trust fund is going broke. They now predict that it will go broke right around the corner in 2017.

But rather than work to bridge Medicare's $37 trillion in unfunded liabilities, this bill cuts half a trillion dollars from the Medicare Program to fund yet another unsustainable health care entitlement program.

By diverting Medicare resources elsewhere, this bill ignores other major problems in the Medicare Program, like fixing the physician payment flaw with the sustainable growth rate formula, or SGR as it is known.

So the few years of extended life this bill would give to the Medicare hospital insurance trust fund is a Pyrrhic victory.

Because the drastic and permanent Medicare cuts in this bill will worsen health care access and quality.

And the Reid bill leaves problems that have long been vexing Congress like the fatally flawed physician payment formula unsolved.

The Reid bill will leave Congress with few options for fixing these problems.

So the Gregg amendment is essential for protecting the Medicare Program. It is essential for making those guarantees real.

The way the Gregg amendment works to enforce those guarantees is quite simple.

The Gregg amendment would make sure that the Medicare Program is not used as a piggy bank to spend for other purposes. It would make sure that the Medicare Program is not being raided to fund this new program as the other side claims.

Under this important amendment, the director of the White House Office of Management and Budget and Medicare's chief actuary would both be required to add up non-Medicare savings in the bill and compare that total to the total of new spending and revenues in the bill.

If non-Medicare savings don't offset all the new costs, then the Treasury Secretary and the HHS Secretary would be prohibited from implementing the new spending or revenue provisions in the bill.

By doing so, the Gregg amendment would ensure that the non-Medicare savings are paying for the new spending in this bill. And it would ensure that Medicare itself is not being used to pay for the new spending in the bill.

It is that simple.

The amendment therefore would prevent massive government expansions at the expense of Medicare beneficiaries.

As you can see, this amendment has teeth. This amendment is real.

As opposed to a mere nonbinding sense of the Senate resolution that the other side has offered to pretend to protect Medicare, the Gregg amendment requires action to protect the Medicare Program.

The Gregg amendment is the enforcement mechanism for the guarantees the other side says they are making to protect Medicare benefits.

Slashing Medicare payments to start up another new unsustainable government entitlement program is not the way to address a big and unsustainable budget.

That is why I support the Gregg amendment. And I urge my colleagues to do the same.

Vote to protect Medicare.

Vote to keep Medicare from being used to fund a separate new program.

Vote to keep Medicare funds from being siphoned off.

Vote to put in place a real guarantee that Medicare funds won't be used.

Vote to back up those promises with real action.

I yield the floor.

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

Mr. ENZI. What is the status of the time?

The PRESIDING OFFICER. The minority has 50 seconds remaining, and the majority has 16 minutes 48 seconds.

Mr. ENZI. I will reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I ask unanimous consent to be recognized for 5 minutes under the majority time.

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

Mr. DURBIN. Mr. President, one of the amendments we are about to consider is offered by the Senator from Nevada.

We know medical malpractice is an issue in this country. The Institute of Medicine tells us that 98,000 Americans die each year from medical malpractice. Many more are injured. In the United States of America each year, there are about 11,000 medical malpractice claims paid.

There is a concern about the impact of medical malpractice on the practice of medicine. That is why President Obama and this legislation were looking together for ways to reduce medical malpractice, negligence, and errors. We are looking for ways to reduce any number of lawsuits that may not be necessary. That is a good and positive thing for us to do.

Unfortunately, the amendment offered by the Senator from Nevada is not a good amendment to achieve that goal because what the Senator from Nevada does is puts together a formula for compensating the lawyers who represent the victims of medical malpractice and reduces the amount of money that is available. I want every single dollar we can bring to the victims of medical malpractice, but the fact is, in our country today, most victims are not wealthy, and the only way they can bring a lawsuit is if the lawyer says it is a contingency fee. If you, the victim, win, then I will be paid. If you lose, I am not paid. It is the only way many people of modest means can get into a courthouse.

The Senator from Nevada wants to limit the amount of money that can be paid to the attorneys, limit the opportunity for victims to be represented. If his goal is to reduce the money paid to lawyers, you would think the amendment would also reduce the money paid to defense lawyers, those insurance

company lawyers who are at the other table in the courtroom. Studies show that 50 percent more is paid to them than paid to the victims' lawyers. But the Senator from Nevada does not restrict their payment in any way. In other words, if you are going to try to defeat a victim of medical malpractice in a courtroom, you can spend an unlimited amount of money, according to the Senator from Nevada. However, if you are going to represent that victim, he would limit the amount of money that counsel, that attorney can be paid. It will mean fewer victims will have lawyers, and maybe some of the lawyers they have will not be the best because of the amendment offered by the Senator from Nevada. That is bad policy. It is not fair to the victims because many of these victims are innocent victims.

I recall a woman in Chicago who went to one of our more famous hospitals for the simple removal of a mole from her face. She was administered a general anesthesia, and during the course of the general anesthesia, the oxygen, which she was receiving, exploded, caught fire, and burned off her facial features. She went through repeated reconstructive surgery, scarring, disfigurement, pain and suffering.

She was an innocent victim. She did nothing wrong. She wanted to make sure her medical bills were paid, her lost wages were paid, there was compensation for her pain and suffering. She was not a wealthy person. She went to an attorney, who said: I will take the case, but it is a contingency. If you win, I am paid. If you lose, I am not paid.

What the Senator from Nevada does with his amendment is limit the opportunity for innocent victims, just like her, to go into a courtroom, into our court of justice, and see justice at the end of the day. That is not a just result. We need to stick with this bill, which moves us forward, with innovative ways to reduce medical errors, reduce medical malpractice, and find ways to resolve the differences between medical providers and the patients in the fairest possible way. That is what this bill does. That is what we should do.

The amendment that has been offered by the Senator from Nevada fails to reach that goal and is fundamentally unfair and unjust to victims who are just asking for a day in court and for the compensation which they deserve for their injury.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 2 minutes to the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas.

AMENDMENT NO. 2905

Mrs. LINCOLN. Mr. President, I think it is so important we look at the choice we will be making when we vote on this amendment in a few minutes. It is very simple. When health insurance reform becomes law, health insurance companies will receive millions of new customers purchasing their product for the first time.

My amendment is intended to encourage those insurance companies to put the additional premium dollars they will be bringing in with the volume of new customers back toward lowering their rates and making more affordable coverage for consumers, not putting it in their own pocketbooks.

Where health insurers spent more than 90 cents of every dollar on patient care in the early 1990s, that number has decreased dramatically to just over 80 cents for every dollar in 2007, and even more so in recent years.

According to testimony delivered in the Senate Commerce Committee earlier this year, this trend has translated into a difference of several billion dollars in favor of insurance company shareholders and executives at the expense of health care providers and their patients.

I think it is so important we understand what it is. This amendment does not dictate what insurance companies can pay their executives. They have the complete ability to pay what they choose. It is not a salary cap. But it does limit the American taxpayers' subsidization of outrageous pay and, instead, devotes those resources to protecting Medicare.

A vote for this amendment is a vote in support of strengthening the Medicare trust fund. A vote against this amendment is a vote in support of having the IRS write a check of $650 million to the health insurance companies to subsidize the multimillion-dollar salaries they are paying their executives.

So I urge my colleagues to support this effort on behalf of the American taxpayer and our seniors and to vote in favor of our amendment.

Mr. BAUCUS. Mr. President, how much time is remaining on our side?

The PRESIDING OFFICER. There is 9 minutes 39 seconds remaining.

Mr. BAUCUS. Mr. President, I yield 9 minutes 39 seconds to my esteemed friend from Vermont.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Mr. President, I thank the senior Senator from Montana.

AMENDMENT NO. 2927

Mr. President, let me wear my hat as chairman of the Senate Judiciary Committee and talk about the amendment we are going to vote on to cap attorney fees. It is a one-sided amendment. It does not hurt attorneys. It hurts injured Americans who seek to recover damages in our court system. It may not be obvious to the nonlawyers listening to this debate that many ordinary Americans who suffer an injury through another's negligence cannot afford to pay for the legal representation they need to go to court.

Our legal system allows for a plaintiff and an attorney to negotiate to determine what the compensation is going to be. In these cases, the parties sign a contract where the attorney may agree to work on a case with no compensation at all unless the victim ultimately receives compensation from the doctor or hospital responsible for the injury. This is called a contingency fee. In other words, a judge and a jury have to agree that person was injured and deserves this compensation. The parties do not do that. This allows all Americans, not just the wealthy, to have their day in court.

It should also be noted that if a judge believes a compensation agreement is unfair to the victim, or if they believe it is disproportionate, the judge has the power to reduce the fee. I believe this is the same in virtually every State in this country. States have regulated the area of attorney compensation extensively, striving for reasonableness. States have done this. Doesn't that make the most sense that the States decide?

Let's not forget that lawyers only are compensated if the client's case is successful and if a jury finds that a wrong was committed and if that jury finds they should be compensated. This is not some kind of windfall. It is the result of an attorney's very hard work to redress a wrong.

The pending amendment would override all of these traditional considerations. It would impose a flat cap on all attorney fees for significant injuries. But the amendment would not cap the attorney fees of those representing a negligent hospital or doctor. That hospital, those doctors—their insurance companies could pay any amount of money they wanted, for example, in the case—and there have been cases like this—where the wrong leg was amputated by mistake or a person was given the wrong medicine and they end up paralyzed.

But this amendment says, if that person who was paralyzed wants to sue, we are going to cap the amount of compensation that could be possibly paid to their attorney. But for the person who wants to escape liability for giving the wrong medicine that paralyzed a patient—their insurance companies, their hospitals—they can pay all however much they want for attorneys. They can pay their own counsel 10 times what a plaintiff's attorney might get in their effort to prevent a hospital or doctor from being held liable for that horrible mistake.

Trust me, this gives a defendant every incentive to prolong litigation. Why should they settle? Why should they admit wrongdoing? They have the deep pockets. Yet through this amendment, a plaintiff would be limited by the actions of the Senate—made up of 100 people who can afford a lawyer, unlike many of the people who are injured? And so are we going to say that the Senate has capped what a plaintiff's lawyer can get? By the way—wink, wink, nudge, nudge—if you are the hospital, the insurance company

for a doctor or somebody who has done a grievous wrong, just keep this thing rolling long enough because you have the money and you can just beat it down.

When a patient receives more than $150,000 in medical expenses or compensatory or other damages, it is because the injury is severe and ongoing or because it resulted in death. Those patients are going to have a tougher time finding someone to hold the person who harmed them accountable. Adding this insult to injury does not further the laudable goals of the pending health care bill. We should be increasing patient safety and health, not punishing those who have already been injured by wrongdoing.

I understand that yesterday the junior Senator from Nevada identified several prominent Democrats as having supported a similar amendment offered by Senator Kennedy a decade ago in a Republican-controlled Senate. I am not surprised by this tactic, given the disappointing tenor of the debate. Of course, upon a review of the actual vote, anyone would see that several Senators in this Chamber, including this one, opposed a motion to table Senator Kennedy's amendment. That is hardly the same as advocating a cap on fees.

It is also worth noting that in 1995, the Senate was considering a draconian products liability bill, not a health care bill. At that time, the then-Republican majority was attempting to go further than any other Congress in history to prevent injured Americans from recovering damages from the corporations that hurt them or their children.

I am relieved that legislation in 1995 never became law. I can see why some might have wished it had. Maybe they knew what was going to come because after that, what came to light were many recent incidents of harmful products that had been introduced into commerce—many of them toys for little children—and nothing could have been done about it had that bill become law. If that bill had become law, I fear we would have seen many more deaths or serious injuries among children as a result of faulty products.

I find it ironic, given the often-professed loyalty to the sovereignty of the States and the sanctity of private contracts, many on the other side of the aisle now seem to have no concerns about the vast Federal intrusion into these areas of traditional State control that this and other medical malpractice reform proposals represent.

Basically they are saying: Oh, we are all for States rights and sovereignty of the States except when it may cost some of the big insurance companies some money. We are all in favor of the sanctity of private contracts—except when it may cost some of the big insurance companies some money.

So I am going to oppose the amendment offered by Senator ENSIGN. It is unfair. It will only hurt Americans who have already been injured by making it more difficult for them to gain access to our court system.

I yield the floor.

Mr. BAUCUS. Mr. President, how much time remains on this side?

The PRESIDING OFFICER. A minute and a half.

Mr. BAUCUS. A minute and a half. I yield 1 minute to my friend from California.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, I thank the Senator.

I have been listening to this debate. It has been very interesting. It is very clear what this amendment does. It hurts the victims who, through no fault of their own, get hurt in a medical malpractice case by essentially making it very difficult for them to get the best attorneys. Some of these cases cry out for the best attorneys.

But let me tell you, I have been in Congress since the 1980s. When a House Member or a Senator gets into trouble, do you know the first person they call? An attorney—the best attorney—and they do not come on this floor and say: Oh, let's make sure those attorneys do not earn enough money. They are willing to pay whatever it takes with their campaign accounts. By the way, that is all legal.

But I find it amazing that Senators—who the first person they call when they are in trouble through their work is an attorney—would wind up going after victims the way they do. When they are a victim of a problem, as they see it, they get the best attorneys and they pay the high price. It is just not right.

The PRESIDING OFFICER. Thirty seconds remain.

Mrs. BOXER. I hope we will defeat the Ensign amendment.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, let me, in closing, remind Senators that the Senate is about to conduct two back-to-back votes. The first vote will be on the Lincoln amendment on executive compensation. The second vote will be on the Ensign amendment on attorney's fees.

Mr. President, I yield back the remaining time.

The PRESIDING OFFICER. Fifteen seconds remains on the minority side.

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, the Ensign amendment is going to come down to a choice: Are you on the side of the patients or are you on the side of the trial bar, personal injury attorneys. That is what it comes down to. Personal injury attorneys will be able to, on their contingency fees—the first $150,000 they will be able to collect 33⅓ percent. Anything above that, we are going to cap them at collecting 25 percent.

This was from an amendment that was offered in 1995 by Senator Edward Kennedy. Twenty-one Members of the current Democratic majority who were also Members of the Senate in 1995 who voted for that amendment. Let's see how that vote comes out today. It is the right amendment. Let's be on the side of the patient instead of the side of the personal injury attorneys.

The PRESIDING OFFICER. All time has expired.

The question is on agreeing to the Lincoln amendment.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 42, as follows:

[Rollcall Vote No. 365 Leg.]

YEAS—56

Akaka
Baucus
Bayh
Begich
Bennet
Boxer
Brown
Burris
Cantwell
Cardin
Casey
Dodd
Dorgan
Durbin
Feingold
Feinstein
Franken
Gillibrand
Hagan
Harkin
Inouye
Johnson
Kaufman
Kerry
Kirk
Klobuchar
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln
McCaskill
Menendez
Merkley
Mikulski
Murray
Nelson (NE)
Nelson (FL)
Pryor
Reed
Reid
Rockefeller
Sanders
Schumer
Shaheen
Snowe
Specter
Stabenow
Tester
Udall (CO)
Udall (NM)
Warner
Webb
Whitehouse
Wyden

NAYS—42

Alexander
Barrasso
Bennett
Bingaman
Bond
Brownback
Burr
Carper
Chambliss
Coburn
Cochran
Collins
Conrad
Corker
Cornyn
Crapo
DeMint
Ensign
Enzi
Graham
Grassley
Gregg
Hatch
Hutchison
Inhofe
Isakson
Johanns
Kyl
LeMieux
Lieberman
Lugar
McCain
McConnell
Murkowski
Risch
Roberts
Sessions
Shelby
Thune
Vitter
Voinovich
Wicker

NOT VOTING—2

Bunning
Byrd

The PRESIDING OFFICER. On this vote, the yeas are 56, the nays are 42. Under the previous order, requiring 60 votes for the adoption of amendment No. 2905, the amendment is withdrawn.

Mr. REID. Mr. President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. Mr. President, I have had a brief conversation this afternoon

with the Republican leader. We originally were not going to offer a side-by-side to the Gregg amendment. We have one more vote. We would like Senators GREGG and PRYOR to lay down their amendments after that. Because we have told everybody we wouldn't be voting late tonight, we need to complete work on these matters in the morning. So we will debate this tomorrow.

It is my understanding that tomorrow there will be a bipartisan amendment on abortion. We can debate the Pryor and Gregg thing in the morning, and then we will debate abortion, and we will be able to dispose of the Gregg and Pryor matters no earlier than 3:15 tomorrow. So we are going to be debating these two things tomorrow.

I say this off the subject: We have been grinding things out here for some time on a very partisan basis. I was confronted yesterday with an issue. We are here working on a Sunday. We had the President come here to talk to the caucus. The Republican leader said: I don't really think that is fair. Why should we be out of session? It is your caucus. So I said: You keep talking; you can preside. I had no concern about any untoward action taken. In a situation such as that, I had no problem. I trust implicitly Senator MCCONNELL and Senator KYL.

I hope that is kind of a breakthrough here. We have to start trusting each other. It is rarely done. I have never seen that happen before. I think it is the right thing to do. I am disappointed that there weren't more Democrats listening to what they had to say. From a procedural perspective, I never doubted that everything would go fine.

We are going to have one more vote. We will not be in session much longer today.

The PRESIDING OFFICER. The minority leader is recognized.

Mr. MCCONNELL. Mr. President, I thank the majority leader. I did suggest yesterday that, since the President was not meeting with us, we had nothing constructive to do during that hour. I suggested that we be allowed to speak. We worked that out in our first bipartisan moment on this bill, as he indicated.

With regard to the agenda tomorrow, as the majority leader indicated, we have the Gregg amendment, the Pryor amendment, and the abortion amendment. We will have an additional amendment on this side as well. That is up to four.

Mr. REID. A counter to the abortion amendment or something like that?

Mr. MCCONNELL. No.

Mr. REID. Just an additional amendment.

Mr. MCCONNELL. Yes.

Mr. REID. Mr. President, I don't really know who is going to offer the amendment tomorrow for sure, but it is an issue I want to get out of the way. I think we all do. So it is OK. It will be our slot, no matter who will be the first person on the amendment.

AMENDMENT NO. 2927

The PRESIDING OFFICER. There is now 2 minutes of debate prior to a vote in relation to amendment No. 2927 offered by Senator ENSIGN.

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, the 2,074-page health care bill before us has a provision on medical liability reform. Here are the savings: zero.

Back in 1995, Senator Edward Kennedy offered an amendment on liability reform to cap attorney's fees. Twenty-one current Democratic Senators, who were Members at that time, voted for that amendment. This chart lists the Members who were in the Senate then.

The Members from the other side of the aisle have made arguments that plaintiffs need these contingency fees to be that high. Let me quote an abstract of a study written in the Washington University Law Quarterly:

> Since 1960, the effective hourly rates of tort lawyers have increased 1,000 to 1,400 percent (in inflation-adjusted dollars), while the overall risk of nonrecovery has . . . decreased materially for such high-end tort categories as . . . medical malpractice.

Mr. President, the complete study that I just quoted an abstract of, is entitled, Effective Hourly Rates of Contingency Fee Lawyers: Competing Data and Non-Competitive Fees. I would urge all of my fellow Members to review that study.

Let me also quote from Howard Dean, who said:

> The reason why tort reform is not in the bill is because the people——

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

Mr. ENSIGN. Mr. President, I ask unanimous consent for 30 more seconds.

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

Mr. LEAHY. Reserving the right to object. If the Senator receives an extra minute, then we will have an extra minute on this side.

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

Mr. ENSIGN. Howard Dean said:

> The reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the plain and simple truth. Now that's the truth.

That is a quote from Howard Dean.

We have a choice. We can be on the side of personal injury attorneys or we can be on the side of the patients. I think we should be on the side of the patients and vote for the Ensign amendment.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Mr. President, it is hard to respond to all the inaccuracies in the statement of the junior Senator from Nevada.

One, incidentally, he may be interested in knowing, as I was leaving Burlington, VT, this morning after saying goodbye to a number of our Guard members I ran into Howard Dean. He hopes we will pass the bill that is on the floor.

Second, the motion he talks about and those who voted, including this Senator, was a procedural motion on a question of tabling Senator Kennedy's amendment. We thought he should be allowed to have a vote. It was not a vote in favor of caps.

Lastly, if you look at what he has done with this amendment, he is saying that the insurance companies and the hospitals or somebody who may have cut the wrong leg off or paralyzed you by giving you the wrong medication, they can spend all the money they want to stop you from getting any relief. You, however, will be limited and the Federal government will override the laws of your State and tell you what you can contract for on fees with your attorney.

In other words, the people who caused the damage can spend any amount of money they want to escape liability from the damage. The poor individual who has been damaged would not have an equal chance at recompense. Come on. Is the Senate actually going to vote for something like that? I would hope not.

Mr. ENSIGN. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 2927.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 32, nays 66, as follows:

[Rollcall Vote No. 366 Leg.]

YEAS—32

Alexander	Grassley	McCain
Barrasso	Gregg	McConnell
Bond	Hagan	Murkowski
Brownback	Hutchison	Roberts
Burr	Inhofe	Sessions
Coburn	Isakson	Snowe
Corker	Kohl	Thune
Cornyn	Kyl	Vitter
DeMint	Lieberman	Voinovich
Ensign	Lincoln	Warner
Enzi	Lugar	

NAYS—66

Akaka	Carper	Franken
Baucus	Casey	Gillibrand
Bayh	Chambliss	Graham
Begich	Cochran	Harkin
Bennet	Collins	Hatch
Bennett	Conrad	Inouye
Bingaman	Crapo	Johanns
Boxer	Dodd	Johnson
Brown	Dorgan	Kaufman
Burris	Durbin	Kerry
Cantwell	Feingold	Kirk
Cardin	Feinstein	Klobuchar

Landrieu	Nelson (NE)	Shelby
Lautenberg	Nelson (FL)	Specter
Leahy	Pryor	Stabenow
LeMieux	Reed	Tester
Levin	Reid	Udall (CO)
McCaskill	Risch	Udall (NM)
Menendez	Rockefeller	Webb
Merkley	Sanders	Whitehouse
Mikulski	Schumer	Wicker
Murray	Shaheen	Wyden

NOT VOTING—2

Bunning	Byrd

The PRESIDING OFFICER. On this vote, the yeas are 32, the nays are 66. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is withdrawn.

Mr. DURBIN. Mr. President, I move to reconsider the vote and to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I am going to ask to have printed in the RECORD a letter dated December 1, 2009, from the insurance commissioner of the State of Oklahoma—she happens to be of your party, the majority's party—outlining the significant problems that she sees for our State if this bill becomes law. This is not a partisan document. This is a document that relates to what is going to happen to Oklahoma.

If I might summarize, very shortly: It will increase premium costs and increase the number of uninsured people in Oklahoma. That is according to our State insurance commissioner, who is of your party. It will decrease the amount of availability of insurance to people who do not have insurance today.

The letter states it will not rein in the cost. In fact, it will increase costs for everybody else in the State of Oklahoma. It will drive up costs and increase the number of uninsured. It will increase the costs for the private plans, negatively impacting medical providers and the health delivery system in Oklahoma, and it will encourage fewer businesses in Oklahoma to offer benefits.

That is a fairly strong indictment from somebody who cares about the people of Oklahoma and what is going to happen in health care.

Mr. President, I ask unanimous consent to have printed in the RECORD this letter from the State insurance commissioner of Oklahoma.

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

OKLAHOMA INSURANCE DEPARTMENT,
STATE OF OKLAHOMA,
Oklahoma City, OK, December 1, 2009.

Re Senate Leadership Bill Patient Protection and Affordable Care Act.

Senator TOM COBURN,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR, I appreciate the opportunity to give you an Oklahoma perspective on the latest health care reform measure being considered by the US Senate. As you are well aware, the challenges associated with health care in America are immense. These complex problems require solutions grounded in fact and sound deliberation.

Large numbers of uninsured Oklahomans generate more than $954 million dollars in uncompensated medical care each and every year in our state alone. This cost is shifted to those with insurance. Recent estimates indicate that this adds an additional $2,911 annually to health insurance premiums for an Oklahoma family of four.

As Oklahoma Insurance Commissioner, I strongly support efforts to provide our citizens with high quality health care and affordable health insurance. Many features of the Senate Bill attempt to accomplish this, at least in part, when taken together. However, in the absence of a strong inducement to purchase coverage, the consequences of adverse selection can cause market disruption, higher costs and lower than desired take-up rates.

IMPACT TO OKLAHOMA

(1) Individual Mandate:

The Oklahoma Health Care Authority has estimated that there are nearly 600,000 uninsured working Oklahomans—nearly half between the ages of 19 and 32. There is no indication that most of those uninsured would voluntarily enroll in any health benefit plan.

Our popular Insure Oklahoma individual plan offers comprehensive, guaranteed issue coverage to individuals earning less than 200% of federal poverty level for less than $40 per month, yet we have only 6,000 covered by that plan and most are over age 30. A healthy 25-year-old male in Oklahoma can purchase a comprehensive individual health insurance policy from a major Oklahoma medical insurer for just $1,634 annually. In Oklahoma, affordability is not the issue for this age cohort. Therefore, we support an individual mandate to purchase health insurance that includes a strong inducement to take up health coverage to avoid the likelihood of adverse selection when only the older and healthier are motivated to enroll.

The Senate Leadership bill includes a minor penalty for non-enrollment scheduled to be phased in over a three year period beginning in 2014. The penalty is $95 the first year, increasing to $750 in year three. This penalty is inadequate to induce a large-scale take up of health coverage among Oklahoma's uninsured. Even with generous premium credits, the absence of a strong noncompliance penalty will not encourage the desired and necessary take-up among the young and healthy to offset the greater risk and cost of the older and unhealthier.

(2) Guarantee Issue:

The Senate Leadership bill would require insurers to offer individual plans on a guaranteed issue basis without pre-existing condition limitations. We support guaranteed coverage when accompanied by a mandate to purchase coverage that is strongly enforced. The absence of a meaningful penalty for nonenrollment will likely result in those with chronic or serious health issues purchasing coverage while younger healthier individuals simply choose to pay the nominal penalty. The result will be higher insurance rates due to a higher percentage of insured being higher risk/expense individuals.

(3) Qualified Health Benefit Plans (QHBP):

The Senate Leadership bill would establish ''Qualified Health Benefit Plans'' and require all individual/family plans to conform to QHBP standards by 2014. While the minimum coverage requirements are suitable for some, they restrict individual choice and limit the ability of healthy and/or wealthier individuals from self-insuring part of their risk.

(4) Rating Standards:

The Senate Leadership bill would restrict the use of risk factors in determining rates to geographic area, smoking and age and would limit age bands to a 3:1 ratio. The age band restriction will shift the cost of the older individual to the younger individual. Blue Cross estimates that this factor alone will increase the base cost for a healthy 25-year-old by 44 percent in Oklahoma. This higher cost burden on the young will further discourage coverage take-up and drive up costs to the remaining insured's.

(4) Employer Penalties:

The Senate Leadership bill would impose a penalty on employers who do not offer coverage equal to $750 for any employee who purchases coverage through a state exchange. This penalty is inadequate to induce an employer to establish a plan. Most employers who do not offer coverage have fewer than 50 employees (only 37 percent of Oklahoma small businesses offer coverage compared to 48 percent nationally) and most uninsured Oklahomans work for small businesses. This nominal penalty creates a potential incentive for certain small employers who currently offer coverage to employees to drop their plan and simply incur the penalty at less expense than the cost of a plan—particularly once the small employer tax credits sunset.

(5) State-Based Health Insurance Exchanges:

The Senate Leadership bill would require the formation of state-based exchanges from which individual coverage would be solely available and small group insurance may be purchased. While we support the state-based exchange concept and are currently in the planning stages for a similar concept here in Oklahoma, the infrastructure costs have been estimated in the millions of dollars. In the absence of a financial grant, current state budget limitations will preclude Oklahoma from making the necessary investment to create the exchange.

(6) Public Health Insurance Option:

The Senate Leadership bill would allow for a federal ''Public Health Insurance Option'' from which states may opt-out. Oklahoma would likely resist participation as long as the private insurance market remains robust and competitive. Although the bill provides that the federal government would ''negotiate'' provider rates, experience with Medicare and Medicaid suggests that reimbursement rates for a federal public option would result in low reimbursement rates.

Currently, our medical provider community relies on private pay to make up the difference in cost of services over government reimbursement rates resulting in higher private insurance rates—more cost-shift. In addition, we have concerns over the potential for government to assert an unfair advantage that would adversely affect our insurance markets and further stress our health care delivery system.

(7) Health Insurance Cooperatives (Co-Ops):

The Senate Leadership bill would provide funding to establish non-profit health insurance ''co-ops,'' We question the likelihood that this notion will produce a lower cost option while meeting all requirements stipulated in the bill (specifically, benefit and solvency requirements). Some of the principles embodied in this idea already exist. For example, Oklahoma's largest health insurer, with nearly 30% of the Oklahoma health insurance marketplace, is a mutual company owned by policyholders for the benefit of policyholders.

(8) Premium Credits:

The Senate Leadership bill would provide ''Premium Credits'' for individuals with incomes up to 400% of FPL. The majority (approximately 65%) of Oklahoma's uninsured population have incomes less than 250% of FPL. Currently, 74% of Oklahoma's total population has incomes of 400% of FPL or less.

(9) Medicaid Eligibility Expansion:

The Senate Leadership bill would increase eligibility requirements for Medicaid. Recently, the Oklahoma State Coverage Initiative (SCI) process reached consensus and recommended that Medicaid be extended to adults with incomes up to 100% of FPL. The Senate Leadership bill would expand eligibility to all non-elderly persons with incomes up to 133% of FPL. This would increase Medicaid rolls by an estimated 285,000 adults and the state's annual cost share by $116 million. This rough estimate is based on current Medicaid experience and does not include working-aged individuals who have not accessed reasonable and timely medical care due to an inability to pay. Our concern is that the cost of this expansion for the state is severely underestimated.

(10) Long-Term Care:

The Senate Leadership bill would provide for a federal, voluntary long-term care insurance plan. This plan appears to directly compete with the private insurance market based on reasons other than need.

(11) Anti-Trust Exemption:

The Senate Leadership bill would leave in place the anti-trust exemption established by the McCarren-Ferguson Act. We support such a decision. This exemption has long provided for a more competitive insurance marketplace and has facilitated solvency among carriers.

(12) Controlling Cost:

As mentioned in the opening of this letter, coverage is essential to increasing access to affordable health care. However, this bill does very little to address rapidly increasing health care costs. Data shows that the number one driver in health insurance premium costs are increased medical costs and utilization. As you know, on average, between $0.80 and $0.90 of every premium dollar for a comprehensive health plan is spent directly on benefits to policyholders.

In Oklahoma, we are studying the issue of rising costs as it relates specifically to our non-profit self-insured state plan. Medical costs for the Oklahoma State Employee and Education Group Insurance plan have increased an average of 10% annually in recent years.

Of concern to us are reports from the CBO and others that the Senate reform plan will reduce premium costs. In actuality, we believe premium costs will rise substantially if adverse selection is allowed to occur and if the cost of medical care is not addressed. While the generous premium subsidies contemplated by the bill will indeed reduce an individual's expense in financing their health care needs (a strategy we agree is necessary to ensure affordability), health insurance premiums will not be lower.

Again, I thank you for the opportunity to provide this perspective and I hope that you have found it helpful. If you wish to further discuss this matter, please do not hesitate to contact me at anytime.

Sincerely,

KIM HOLLAND,
Commissioner.

Mr. COBURN. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent to call up my amendment No. 2942.

I see the Senator from Arkansas is standing. I thought I was supposed to offer my amendment first. Is the Senator from Arkansas supposed to go first?

Mr. PRYOR. I believe the sequence was that I would go first.

Mr. GREGG. I will reserve.

The PRESIDING OFFICER. The Senator from Arkansas.

AMENDMENT NO. 2939 TO AMENDMENT NO. 2786

Mr. PRYOR. Mr. President, I call up amendment No. 2939.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas [Mr. PRYOR] proposes an amendment numbered 2939 to amendment No. 2786.

Mr. PRYOR. I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To require the Secretary to provide information regarding enrollee satisfaction with qualified health plans offered through an Exchange through the Internet portal)

On page 134, between lines 10 and 11, insert the following:

(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

Mr. GREGG. Mr. President, I ask unanimous consent that the amendment of the Senator from Arkansas be set aside so I may call up my amendment.

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

AMENDMENT NO. 2942 TO AMENDMENT NO. 2786

Mr. GREGG. Mr. President, I call up amendment No. 2942.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from New Hampshire [Mr. GREGG], for himself, and Mr. CORKER, Mr. THUNE, Mr. COBURN, Mr. ENSIGN, Mr. ISAKSON, Mr. BURR, Mr. ENZI, Mr. ALEXANDER, Mr. BARRASSO, Mr. CORNYN, Mr. MCCAIN, and Mr. LEMIEUX, proposes an amendment numbered 2942 to Amendment No. 2786.

Mr. GREGG. I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To prevent Medicare from being raided for new entitlements and to use Medicare savings to save Medicare)

At the appropriate place, insert the following:

SEC. _____. PREVENTING THE IMPLEMENTATION OF NEW ENTITLEMENTS THAT WOULD RAID MEDICARE.

(a) BAN ON NEW SPENDING TAKING EFFECT.—

(1) PURPOSE.—The purpose of this section is to require that savings resulting from this Act must fully offset the increase in Federal spending and reductions in revenues resulting from this Act before any such Federal spending increases or revenue reductions can occur.

(2) IN GENERAL.—Notwithstanding any other provision of this Act, the Secretary of the Treasury and the Secretary of Health and Human Services are prohibited from implementing the provisions of, and amendments made by, sections 1401, 1402, 2001, and 2101, or any other spending increase or revenue reduction provision in this Act until both the Director of the Office of Management and Budget (referred to in this section as ''OMB'') and the Chief Actuary of the Centers for Medicare and Medicaid Services Office of the Actuary (referred to in this section as '' CMS OACT'') each certify that they project that all of the projected Federal spending increases and revenue reductions resulting from this Act will be offset by projected savings from this Act.

(3) CALCULATIONS.—For purposes of this section, projected savings shall exclude any projected savings or other offsets directly resulting from changes to Medicare and Social Security made by this Act.

(b) LIMIT ON FUTURE SPENDING.—On September 1 of each year (beginning with 2013), the CMS OACT and the OMB shall each issue an annual report that—

(1) certifies whether all of the projected Federal spending increases and revenue reductions resulting from this Act, starting with the next fiscal year and for the following 9 fiscal years, are fully offset by projected savings resulting from this Act (as calculated under subsection (a)); and

(2) provides detailed estimates of such spending increases, revenue reductions, and savings, year by year, program by program and provision by provision.

Mr. PRYOR. Mr. President, I ask unanimous consent that no further amendments or motions be in order today.

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

The Senator from North Dakota.

Mr. DORGAN. Mr. President, this issue of health care and health care reform has been an issue that has caused a great deal of advertising and claims on television from both sides, back and forth. A substantial amount of the advertising we have seen has been totally and completely without foundation—completely inaccurate. But, nonetheless, political dialogue in this country allows one to say whatever one wishes, so the very aggressive discussion about this issue of health care has taken on interesting tones—claims by some that Congress is working to undermine the Medicare Program.

The fact is, those of us on this side of the aisle are the ones who created the Medicare Program, at a time when most senior citizens had no health insurance at all. There were no insurance companies in this country tracking down senior citizens and saying: Do you mind if we sell you a policy for health care? At a time when people's lives were going to need an increasing claim on health care benefits, were insurance companies tracking them down and saying: Can I do business with you? Of course they weren't. Over half the American people had no access to health insurance. Folks reaching the end of their lives, retired, would lay their head down on their pillow at night and wonder if tomorrow would be

the day they would get sick and have no health insurance coverage; and wonder if they would get sick, who would treat them or how they would find the money to provide for themselves. So the fact is, this Congress created something called Medicare at a time when it was decided that maybe we should put together a program to give senior citizens an opportunity to be covered with health care.

It was decried as socialism—unbelievable—when we tried to put together this government program to provide Medicare for senior citizens. Some old guy in a little town in North Dakota one night, at a town meeting, got up, and he was so angry with the government. He shook his hand as he spoke. He was a thin, older guy, and his neck was coursing out and bulging so that I thought he was going to have a heart attack right there, shouting about the government. At the end of the meeting, an elderly woman took me aside and said: You know what, I hope you are not upset with Ernie because he's been pretty emotional about a lot of things. He just had open heart surgery and he gets kind of emotional about things.

So I saw the gentleman as he was leaving, and I sidled up to him and I said: I understand you just had open heart surgery, and he said: Yeah. So I asked him if his surgery was covered by Medicare, and he said it was. I said: Well, there is at least one government program that works. He said: Medicare ''ain't'' government. It just ''ain't'' government.

Well, of course, it is government. The reason he had health insurance coverage was because we—that is we the government, the Congress, the American people—decided we weren't going to let people come to the end of their years and not have health insurance coverage.

Some might say: Well, yes, you put together Social Security and Medicare and now you have trouble financing it. That is true. That is true. We have trouble financing it because of success. We can handle success. Our country can handle success. People are living longer and better lives these days—longer and better lives—and they claim more health care during those extra 5, 10 or 20 years they are living.

I have often told my colleagues that I have an 89-year-old uncle who runs in the Senior Olympics. He runs the 50 meter, the 100 meter, and the 200 meter. He runs the 100 meter in under 19 seconds at age 89. Would that have happened 30 years ago? Not likely. But people are living longer and healthier lives and it causes some strain on Social Security and Medicare, but we can deal with success. Surely, we can deal with success.

Now we are talking about a system of health care that doesn't work for everybody or it doesn't work very well for many people and it works very well for some others. But should we do nothing or should we decide to try to tackle this question?

I walked into a restaurant about 2 weeks ago, and I saw what several of my colleagues have seen: advertisements on the wall. This particular restaurant, as you walk through the door, has a plate glass window up to the ceiling, and it had a couple of advertisements on it. Both of them were advertisements for people who needed to raise money to try to pay for their health care costs—spaghetti dinners, bake sales, various things to ask people to come and chip in some money for their health care needs.

Let me read a few of them. I will not read the name, but this one is a benefit for Chris's family: A spaghetti feed and silent auction is going to be held from 5 to 7:30 p.m. to benefit Chris. He is a sheriff's deputy who was shot in the head and the abdomen while on duty and is still recovering at a rehabilitation hospital outside of Denver, CO. They will have a spaghetti feed and silent auction to try to raise the funds to benefit that family for their needs.

Here is a spaghetti supper, silent auction, bake sale, free-will offering for supper or donations to be made to the Duane fund at the Community National Bank. He has stomach cancer that has spread to other areas and is undergoing various treatments and needs help with medical and living expenses.

This is what you see on the side of the wall in cafes, posted to a bulletin board downtown: A burger supper and free-will offering to be held for Amy. In July, Amy was diagnosed with uterine cancer, which has metastasized to the lymph nodes. She has had surgery and is now undergoing chemotherapy radiation and needs to raise funds for health care costs.

Here is a pancake breakfast to be held for Sean in the school cafeteria. Scrambled eggs, pancakes, and sausage will be served, and there will be a free-will offering. Sean's infant daughter was born with a heart defect and needs corrective surgery and a lengthy stay in the hospital. The staff is hosting the event to defray the expenses so they can provide the funds to try to afford this very expensive medical treatment.

Joyce is the mother of Brandy. Brand is a 16-year-old who was involved in a car accident weeks after her parents decided to give up their health care coverage so they could afford mortgage payments. The family had a meatball and mashed potato dinner benefit last month to help pay for Brandy's health care needs.

I have a long list. The list goes on, and one wonders whether we should be oblivious to that, that we walk into the business places in the downtowns and the Main Streets of our communities and see that there are many people who have to have a spaghetti supper or burger feed to see if they can raise enough money just to get to the hospital, just for transportation, let alone the surgery, let alone the medical treatment.

I think it is the worst, not the best of our political system that when we debate these things, there is so much misinformation, so much bad information that is alleged about legislation to try to deal with health care.

It is interesting to me, I do not know of an attempt of a government takeover of the health care system. I have heard it 1,000 times on this floor. I am not familiar with any legislation that has been discussed that represents a government takeover of health care. I am just not familiar with it. Maybe it exists in some cubbyhole someplace, but I have not seen it. But I know why the allegation comes to the floor every day—because it works. Scare the devil out of people. Somebody is trying to have a complete government takeover of the health care system. I wouldn't support a government takeover of the health care system. I wouldn't support it. I do support Medicare. By the way, that is a government-created system to make sure all citizens have access to health care because the private industry is not going to get there. They didn't prior to Medicare, and they wouldn't now if we didn't have Medicare.

The very people who come and talk about government health care, it is interesting they do not come to the floor of the Senate offering an amendment that would abolish Medicare. I don't understand—if, in fact, they really do not like this at all, they should be offering an amendment that abolishes the Medicare Program, saying it is just not worthy, to have a system in which the government tries to guarantee health care for America's seniors. The reason I think they do not is they agree with Medicare. They believe Medicare should exist, and as a result, they support a form of government health care, at least for senior citizens.

What I want to do briefly—I will talk more about that later. I am going to offer an amendment. I expect it will be tomorrow night or Tuesday.

I see Senator GRASSLEY is on the floor. He has been a cosponsor of this legislation, Senator SNOWE, Senator MCCAIN and others—many on my side—Senator STABENOW. There are a lot of folks who have worked on this, the issue of prescription drug importation. I want to make a couple of comments about that. I have not been on the floor speaking about the health care much until now, and I will be offering this amendment; I guess it will either be tomorrow evening or I expect it to be on Tuesday. But I want to make a couple of comments about it because I think it is very important.

I don't think you can leave the issue of health care, having tried to do things about the escalating costs—some people talk about bending the cost curve, whatever that means. All I know is, putting the brakes on increasing costs at the time they are skyrocketing is important for businesses, for families, for individuals. The question is, What about prescription drugs? How can we possibly leave that subject behind?

There are a whole lot of people in this country who are taking prescription drugs to manage their diseases and keep them out of an acute-care bed in a hospital. Cholesterol-lowering medicine, blood pressure-lowering medicine—a whole lot of people take both every day of their lives and do so to manage health care problems. Yet what they see with brand-name prescription drugs is a dramatic increase in prices. I want to just give some examples.

This year alone, the average price of brand-name prescription drugs has gone up 9.2 percent, well over quadruple the rate of inflation. Justification for that? I see none. Should we do something about it? Should we try to put the brakes on some of this? I think we should. Let's look at some examples. Enbrel, for arthritis, up 12 percent in 2009; Nexium, for ulcers, up 7 percent in 2009; Lipitor, up 5 percent; Singulair, for asthma, up 12 percent; Plavix, up 8 percent; Boniva, for osteoporosis, up 18 percent this year.

All of us understand—you watch television in the morning and brush your teeth, you have a television set there someplace, and they are saying to you: Do you know what you should be doing? You should be going to talk to your doctor. You should talk to your doctor and see whether the purple pill is right for you.

I don't know what the purple pill is, but the television commercial is pretty seductive. You almost feel like: I ought to find a doctor someplace; maybe I am missing something; maybe the purple pill is right for me.

The list go goes on and on. Flomax, Lipitor—you name it, they are advertising it relentlessly. Go ask your doctor whether these pills are right for you.

The problem is, the American people, with respect to the price of prescription drugs, are charged the highest prices in the world. Not even close—brand-name prescription drugs cost much more here than anywhere else in the world.

I have in my desk something I would like, by consent, to show. These are two bottles of Lipitor. This is, by the way, the most popular cholesterol-lowering drug in America. These bottles, as you can see, are the same shape. These pills are made in the same place. They are made in Ireland and then shipped around the world. This bottle was shipped to the United States. This bottle, with 20-milligram tablets of Lipitor, was shipped to the United States. You get to buy them as a U.S. consumer for $4.48 per tablet. This bottle—one is red, one is blue, same size, same pills, same company—this bottle went to Canada, same 20-milligram tablets. No, it was not $4.48, which the American consumer paid, it was $1.83. It does not matter whether it is Canada, Italy, Spain, Germany, France—I would cite exactly the same numbers in terms of the American people being told they should be paying double, triple, in some cases quadruple what other people are paying for exactly the same prescription drug.

On this chart, this represents inflation—the yellow line. This represents the increased prices for prescription drugs—the red line—which I think demonstrates clearly why something ought to be done.

A group of us have put together a piece of legislation that is simple, and, in my judgment, very effective in addressing this problem that the American people are charged the highest prices in the world for brand-name prescription drugs.

An example of that, I sat on a straw bale out on a farm once about a year or so ago with some people at a town meeting. One of the old guys out there—he was about 80 years old—he said: My wife and I have driven to Canada every 3 months so she could buy Tamoxifen to treat her breast cancer.

I said: Why did you do that?

He said: Because we can't afford to buy Tamoxifen in the United States. I bought it for one-fifth of the price in Canada of what it would cost us. My wife has been fighting breast cancer—in her late seventies now—for 3 years, and the only way we could afford the drug was to drive into Canada.

Most people cannot drive into Canada. There is an informal opportunity for people to bring back a 3-month supply on their person if they go to Canada. Most Americans cannot possibly do that. But the same drug is sold all over the world by the major drugmakers, and the difference is they charge the highest prices to the American people.

The question is this: Why shouldn't the American people have some freedom—the freedom to shop for that same FDA-approved drug wherever it is sold if it is sold at a fraction of the price? The answer is, they should have that freedom. Our legislation gives them that freedom.

I assume there will be people coming here and saying: If you pass this legislation, that allows the American people to access, through pharmacists or through registered wholesalers, these identical FDA-approved drugs for a fraction of the price. If you do that somehow, we are worried we will have an unsafe drug supply, we are worried about counterfeit drugs.

In this legislation I put together with my colleagues, Senator SNOWE, Senator STABENOW, and Senator GRASSLEY—a wide range, bipartisan group of Senators—that is pretty unusual. This is a bipartisan amendment, by the way. But in our legislation, we have the significant changes that are necessary to ensure safe drug supply, not just those you would ship in but those you buy here. We talk in our legislation about batch lots and pedigree and a whole series of things. So you track every drug right back through the chain of custody, right to its manufacturer, and that is something we do not do today.

When we offer this, the question is, Do we have the votes to get this passed? We have tried for a long time. We have been rebuffed here and there for various reasons.

There is a supposed "deal" that has been struck with the pharmaceutical industry, for $80 billion. I think the pharmaceutical industry has something like $220 billion a year in revenues, so that is $2.2 trillion over 10 years. A very small fraction of that $220 billion was agreed to by the White House, I guess, and somebody here in Congress.

One of my colleagues who served here years ago said, "I am not for any deal I am not a part of." Most Members of the Senate were not part of any deal. So my expectation is, the time and place and reason to offer this is right now. We can't do health care and leave behind this question of the cost, the price of prescription drugs.

I think the drug industry is a fine industry. I want them to succeed. I want them to be profitable. I want them to be successful. I want them to produce the new miracle lifesaving drugs, and by the way, much of that comes from public investments we make in the National Institutes of Health. But I just want them to change their pricing strategy. Why should the American people be paying the highest prices in the world?

Europe has had a strategy—it is called parallel trading—that they have had in place over 20 years. If you are in England and want to buy a drug from France, no problem. If you are in Spain and want to buy a drug from Italy, no problem. They have done it for 20 years successfully. Somehow, people are suggesting that we can't do what the Europeans do? That is nonsense.

We are going to offer this legislation: myself, Senator MCCAIN, I mentioned Senator STABENOW, Senator GRASSLEY—there are so many Members of the Democratic and Republican side on this. We will offer this legislation, and I hope we will have the 60 votes necessary to pass it. I hope finally, at last—at long, long last—we will have enough people standing on the floor of Senate who will say: You know what, I am on the side of the American people here. I am not interested in having the American people pay the highest prices in the world for prescription drugs. How about some fair pricing for a change, fair pricing for the American people? And how about some freedom, freedom for the American people to access those identical drugs where they are sold at a fraction of the price? Why restrict the freedom of the American people? Everybody talks about this being a global economy. Well, that is so when it benefits everybody else, but what about a global economy that benefits the consumer when they want to access an FDA-approved drug when it is sold elsewhere for a half, quarter, or eighth of the price?

Let's give people a little freedom. I hear people talk about freedom on the floor of the Senate. This will be a bill in which we decide whether we want to

give the American people the freedom to access those low-cost prescription drugs.

I am going to have a lot to talk about when we offer this amendment.

Just this year, again, just this year the price of prescription drugs has increased 9.2 percent.

I showed the chart. There is no reason that brand-named prescription drugs should be on a stepladder like that. What about the people who struggle, trying to figure out how to buy those drugs? Does anybody care about them?

They say the deal that was made with the pharmaceutical industry affects what is called the doughnut hole, and 50 percent of the doughnut hole is being filled if they buy brand-named—I don't care about that. That is a recipe for a stew I was not part of making. What I do care about is a whole lot of folks going to the grocery store where the pharmacy is in the back of the store and they are trying to figure out, what do these drugs cost me this time when I fill them so I know how much money I have left to buy food. Over and over in this country, people are making those choices. There is no excuse for a 9-percent increase in these brand-name prescription drugs this year, in anticipation of health care reform.

The fact is, health care reform ought to contain the kinds of things that begin to put brakes on this.

I am not saying you put the brakes on it by imposing government pricing. I am saying you put the brakes on it by giving the American people the freedom to access those drugs where they are sold at a fraction of the price they are sold here. And you give the American people that freedom, I guarantee you, they will shop where they get the best price on identical drugs, FDA approved. It will force the pharmaceutical industry to reprice drugs in the United States.

A couple quick points in conclusion. President Barack Obama was a cosponsor of this legislation last year when he was a Senator. The Chief of Staff at the White House, Rahm Emanuel, was one of the leaders in the House on this legislation last year when he served in the House. It tells you a little something about the breadth of support that exists or existed for this. Somebody told me at the door as I came in: We are not sure the White House is supporting this. I fully expect the White House to support an amendment they supported last year in the Senate.

There are big issues and small issues. This issue is an important issue. A lot of us have worked for a long time to get it right. We have been thwarted by a very powerful industry that has a lot of friends in this town. I am hoping the consumers have a lot of friends as well. A lot of people are out there struggling to try to figure out how to afford the prescription drugs they need to take. A whole lot of folks are deciding, I guess what I will do is get the prescription drugs the doctor says I should have, and I will cut them in half and see if I can make that work somehow. The next time they show up at the counter, it is 9 percent more.

I say knock off a little of that advertising. There are different reports, but there are some reports that say they spend more money on marketing promotion and advertising than they do on research. How about knocking off a little of that advertising if that is causing some of the relentless price increases.

I want to begin the discussion because we will have a full discussion on this when it comes to the floor. It will be either tomorrow afternoon or Tuesday morning. Senator MCCAIN will be joining me on the floor and many of my colleagues on both sides of the aisle to see if we can't finally lift this piece of legislation and get it over the finish line. It is important for the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I had a chance to hear the Senator from North Dakota. I am not rising to speak on that issue right now, but I support him in that effort. I thank him for working with my staff over a period of years to develop a bill that does not violate any of our trade agreements. That is an important aspect of the work of the Senate Finance Committee on which I serve. I look forward to that debate coming up.

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

Mr. GRASSLEY. I yield.

Mr. DORGAN. I wanted to say it is so rare for us to have a bipartisan amendment. Those of us who have worked on this, including Senator GRASSLEY and Senator MCCAIN and many on my side, will be faced once again with the charge that this would undermine safety and so on. I wanted to make the point that Senator GRASSLEY was one of those who especially worked with us—and Senator MCCAIN—to make sure we had safety in this legislation, pedigrees, batch lots, safety that does not exist now even in domestic supply, let alone imported drugs.

I appreciate the Senator from Iowa working with us on this legislation. This is a good piece of legislation. I look forward to seeing the Senator from Iowa on the floor when we get it to the floor to have that debate.

Mr. GRASSLEY. I thank Senator DORGAN. He gave a very good description just now of how careful this piece of legislation—of which I am a cosponsor—would go not only to make price transparency and price competitiveness much better for the American consumer but to guarantee the same safety we would for drugs imported as we do for drugs produced here.

I rise to speak in a generic way about this 2,074-page bill that is before us, to speak about people who have raised questions about whether this bill is or is not a first step toward a government takeover of health care. I take the position that it is definitely a first step in that direction. If you spend a little bit of time watching any of the cable news stations, you will hear someone talking about how the current health reform proposals represent a government takeover of our health care system. The phrase ''government takeover'' has become a common talking point for people opposed to this pending bill. Unfortunately, these opponents rarely explain why this bill warrants such a claim, that it is a step toward government takeover of the entire health care system or the nationalization of health care. Supporters of these bills don't do much better as well. These supporters dispute the claim but at the same time they seem unaware of all the new roles and responsibilities the Federal Government is taking on in this 2,074-page health care reform bill. I want to explain why I see the pending bills as a government takeover of our health care system.

I don't come to the floor to scare people or misinform them. I am more than willing to listen to different points of view. But if I am going to use the phrase ''government takeover,'' I want to make sure other Senators—and particularly my constituents in Iowa—know what I am talking about. I wish to start with the simplest example of government takeover, the government-run plan. It is sometimes referred to as the public option. This one seems to be pretty straightforward. In other words, the government-run plan is a pretty straightforward example that people can understand the government getting more involved.

If you wonder maybe sometimes why the public at the grassroots is a little bit concerned about the takeover of health care by the Federal Government, remember that it was only a few months ago the Federal Government nationalized General Motors, as an example, and has partially nationalized individual banks and financial institutions—in a sense, taking a big step toward nationalizing the whole financial system with the Federal Reserve system's intimate involvement and the Secretary of the Treasury's intimate involvement in a lot of decision making there or decisions that affect the entire financial system.

We are here with the prospect of building upon other things that have happened this year, having the Federal Government take over health care. The public option is one step in that direction. I see a government-run plan, whether it is an opt out, an opt in, a trigger or a straight government plan paying Medicare rates, as this country's first step toward a single-payer system. A single-payer system is a government-run system, one system for the entire country, as in Canada, without options or choices that people have. I don't want you to take my word for it.

Let's look at a quote from Representative JAN SCHAKOWSKY of Illinois:

A public option will put the private insurance industry out of business and lead to single payer.

I have another quote by Representative BARNEY FRANK of Massachusetts:

If we could get a good public option it could lead to single payer, and that's the best way to reach single payer.

Judging by these quotes, I would say both of these prominent Members of the Democratic party agree that the so-called public option is a first step toward government taking over our health care system. But we don't need to rely only upon sound bites. Let me explain why I see the government-run plan leading to a single-payer system. The government-run plan may start out with some rules to keep it from having an unfair advantage over private insurers. Supporters might say it is on a level playing field with private insurers. They may say it would have to pay the same rates, form networks, and be independently solvent. But I remind people, when they hear those promises today, why something the government is doing can be competitive and not unfair competition with the private sector.

Those same kinds of promises were made during the Medicare debate way back in 1965. Supporters of the bill in 1965 promised the new government health insurance program would not interfere with the practice of medicine and would pay fair reimbursement rates. But over time, as the costs of the program exceeded projections, the government broke promises it made. The pending bills represent a government takeover of our health care system, because I believe the same thing that happened in 1965 with Medicare, the government breaking its promises, will also happen with the so-called public option.

In fact, I want to quote from a recent Wall Street Journal article:

Any policy guardrails built this year can be dismantled once the basic public option architecture is in place . . . That is what has always happened with government health programs.

Isn't that what Representative SCHAKOWSKY and Representative FRANK were saying? Start in a very simple way, saying to people the private sector needs competition. Government will give that competition. But start with a government-run plan so you can end up with a single-payer system, regardless of how innocent it sounded when you first started out. Slowly but surely, the government plan would take over the market. This is just one example of why I see the pending bills as a government takeover of our health care system. But there are others.

I wish to take a look at some health insurance reforms that are within this bill. All of these insurance reforms aren't bad as separate items. But coupled with all the bad things in the bill, it makes it difficult to sort out the good things.

For instance, I support stronger rules and regulations for private insurers. This is within the principle of the Federal Government's constitutional power to regulate interstate commerce, going way back to 1944 or 1945. The Supreme Court ruled that. Then Congress passed the McCarran-Ferguson Act and gave it right back to the States to do, where it has been basically regulated. But this bill brings a lot of that regulation back to the Federal Government. I do support some stronger rules and regulations. Congress should make sure that people are not discriminated against because of preexisting conditions, and people should not have to stay up at night worrying about whether their insurance will be there when they get sick and need it most, just as you wouldn't want your fire insurance on your house canceled at the same time the fire starts in the house.

Those are the kinds of reforms I say are good in this bill and could get strong bipartisan support. But the pending bills go much further than creating stronger rules and regulations.

First, let's keep in mind that under current law, health insurance is primarily regulated under McCarran-Ferguson at the State level. State insurance commissioners and legislatures set most of the rules. The health reform proposals being debated in the Senate and over in the House would have the Federal Government take over these responsibilities. Under the present bills, the Federal Government, either through the Secretary of Health and Human Services, or a newly created office of health choices commissioner, or an unelected Federal health board is going to decide what health insurance has to look like. What every health plan has to cover is what the Federal Government is going to decide.

It is not just a case of ending discrimination. It is a case of the Federal Government saying what that health insurance plan needs to look like. If your current coverage does not meet one of the bronze, silver, gold, or platinum categories set up by the Federal Government—despite the President's promise—you may not be able to keep what you have.

The Federal Government is also going to set a national standard for how much insurers can vary prices between younger and older beneficiaries. These reforms will result in drastic price increases, particularly for younger and healthier beneficiaries. This means millions of people who are expecting lower costs as a result of reform will end up paying higher premiums.

So the Federal Government will decide how much plans can charge and what benefits can be covered. To help make these decisions, the Federal Government will have a newly created comparative effectiveness research program. This program would be similar to the ones in Great Britain and other foreign governments that decide which treatments you can and cannot have.

I want everyone to understand that the principle of comparative effectiveness research in and of itself is not something I oppose because I think when it is used as a way of informing patients and providers about best practices, it is a good thing to have. But I am also worried this research could be used as a tool for government to ration care. Especially the reason for my concern is the recently passed House bill failed to include a prohibition on rationing that was in their original discussion draft. That discussion draft of the House bill, H.R. 3200, stated that the committee should ''[e]nsure that essential benefits coverage does not lead to rationing of health care.''

But, unfortunately, that line was not included in the final bill.

Now, that makes you wonder: When everybody says comparative effectiveness research is not going to be used to ration care, then why would you object to a statement saying: ''Ensure that essential benefits coverage does not lead to rationing of health care.'' Why wouldn't that be in the bill if that is what you believe?

So under these pending bills, you have the Federal Government telling private plans how much they can charge and deciding what benefits they have to cover. Then the Federal Government is going to tell them—again, a Federal intervention in health care and a step toward more nationalization—they are not only going to tell them what benefits they have to cover, but then the Federal Government is going to tell you that you have to buy it.

Understand, as far as I know, in the 225-year history of our great country, the Federal Government has never said you had to buy anything—buy or not buy anything. They do not tell you.

Somebody is going to say: Well, the States make you buy car insurance. Well, under the 10th amendment, the States can do anything they want to that is not prohibited by the Federal Government. But the Federal Government is a government of limited power.

So you have the Federal Government saying you have to buy health insurance. But the government takeover does not stop there. The proposed bills also include the biggest expansion of the Medicaid Program since it was created in 1965. The bills force 14 million more Americans into Medicaid, even though many doctors will not see Medicaid patients. Under current law, the government already pays for about 50 percent of health care. But with the new subsidies and massive Medicaid expansion, the Federal Government will eclipse the private market when it comes to paying for health care services.

I am sure some of my colleagues saw recently released data from the inspector general showing that about 12 percent of Medicare payments were payment errors that could be the result of fraud, waste, and abuse. It is no wonder then that Medicare is scheduled to be insolvent within the next 10 years.

Clearly, the government cannot afford or even manage the programs it

has now. But here we are debating the single largest expansion of government health care in history embodied in this 2,074-page bill.

So I would like to review why I see the current bill as a government takeover of our health care system.

First, there is a government-run plan that will drive private health plans out of business. In fact, some Democratic legislators have said publicly they see it as a first step toward a single-payer system.

Second, States will no longer be in charge of their own insurance markets. The Federal Government is going to take over the responsibility of setting premiums and defining benefits. So regardless of whether you are getting your health insurance through an employer or on your own, when you go to buy a new policy, the Federal Government is going to tell you what you can and cannot buy. If you do not buy the coverage the government has chosen for you, you could end up paying a new tax or even end up in jail under this new intrusive health insurance mandate that is going to be enforced by the Internal Revenue Service.

Interestingly, an analysis of similar health reform legislation said the IRS would have to grow by 25 percent in order to manage all the new taxes, fees, and mandates.

By the way, I have written a letter to the Secretary of the Treasury trying to get exactly some estimate of how much money it is going to take for the IRS to administer this program, and we do not have an answer yet.

Finally, we have the single largest expansion of Medicaid since its inception. Current proposals plan to add 14 million people to the Medicaid Program—a program that States already cannot afford.

All of this begs the question then: At more than 2,000 pages, and about $2.5 trillion in spending when fully implemented, how can anyone say the pending bills do not represent a government takeover of health care? From the government-run plan, to a Federal takeover of private health insurance, to a massive expansion of Medicaid, I find it hard to call the pending bills anything else.

The American people want lower costs, higher quality, and better access. That is clear. I share these goals, but I cannot support any bill that I believe hands our private system of medicine over to a bunch of Washington bureaucrats. That is not what my constituents want, and it is not what this country needs.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SESSIONS. Mr. President, I thank Senator GRASSLEY for his leadership on this issue.

I am going to share some facts and fictions that are relevant to this bill. I think it will explain to anybody who looks at it carefully why Senator GRASSLEY and others who hoped to be able to support this legislation are not able to support it. It is why I am not able to support it.

Supporters of this legislation promise that it will do a number of things. We are being told we should support it and vote for it. But it does not do those things that are advertised of it. I wish it did. I wish we could create something for nothing. I wish we could make these numbers balance, but they do not.

Earlier today, one of our colleagues on the other side of the aisle said: We would not do anything about hurting Medicare. We Democrats, 45 years ago, created the program, and we would not do anything to hurt it.

Well, then, we are going to have a vote. We are going to have a serious vote coming up, probably tomorrow, on the Gregg amendment. Senator Judd Gregg is one of the most knowledgeable persons in the Senate on Medicare. He has worked hard on it for a number of years. He chaired the Budget Committee when Republicans were in the majority, and now he is the ranking Republican. Everybody respects him. He has offered an amendment that would make sure we do not raid Medicare—and that is exactly what this bill would do. If this bill does not raid Medicare, then why wouldn't everybody vote for the Gregg amendment?

We are entering a time in which we will have a defining moment. Some of my colleagues will say they voted for the Bennet amendment. As we said then, the amendment meant nothing. It did not do what they said it would do because it did not prohibit the raiding of the Medicare trust fund. But my colleagues wanted to adopt it. This is why people are angry with Congress—it was a cover amendment.

For a day or two it seemed as if the cover may have worked; that by voting for this amendment, my colleagues who are supporting this legislation could say they voted to not hurt Medicare. They could go back home and say: I voted for the Bennet amendment.

Well, the New York Times—along with anybody who takes the time to look at the amendment—said it was meaningless. And the New York Times supports the legislation. It is meaningless. It was absolutely meaningless. The amendment does not do anything, and will not protect the Medicare program.

We are going to have an opportunity to deal with that tomorrow. The numbers in this bill are not adding up. The way this bill is being financed in part is by a $465 billion raid on Medicare. Well, I am going to raise a number of issues, but I will not do them all today, so you can rest with some relaxation.

As to some of the things that are critical to whether a person can support this kind of reform, the fiction that has been stated is that the bill's net total cost is $848 billion. Well, in truth, when the bill is fully implemented, the first 10 years of full implementation costs $2.5 trillion, three times the number that their supporters claim.

How can this happen? Well, Senator REID and whomever he selected met down the hall in secret, and they talked about the numbers, and they were worried about how to meet the president's claim that their bill would not cost more than $900 billion. They were trying to promise it would be only $848 billion, but the numbers were not adding up.

So what did they do? They delayed the implementation of the expenditures the bill promises for 5 years. So they delay the expenditures, the benefits they promised, for 5 years, but the taxes start now. That way, you can take the first 10 years of the bill, and it looks pretty good because you only have expenditures—the big expenditures—for 5 years, and you have revenue for 10. Well, this is flimflammery. It is not honest. The numbers do not add up.

If you examine the bill's costs when it is fully implemented for 10 years, it is $2.5 trillion, $2,500 billion.

So I would say, first of all, that is a fiction. The fact is that these numbers are not accurate. They did not do what they said they were going to do. The bill does not do what it promises.

No. 2, the President told us in a joint session of Congress that he will not sign a bill that adds one dime to the deficit. Well, that is pretty good. In fact, they produced this $848 billion bill, they say, that it is going to only cost $848 billion. They say, boy, give us a pat on the back. Not only is it going to be deficit neutral and not add to the debt, it is going to increase revenues by $130 billion, and we will pay down the debt. Have you heard that? We are going to pay down the debt.

But they had a number of problems. One of them was they promised to pay the doctors a reasonable fee. Under the existing law, the way it was passed in one of the budget balancing acts, doctors are set to take a 23-percent reduction in their payments in 2011 for doing Medicare work—23 percent—which we know we cannot allow to occur. Doctors will quit doing Medicare. Many of them are having difficulty continuing to see Medicare patients now. We cannot cut them 23 percent. So what did the writers of this bill do? They increased the doctors' reimbursement for 1 year. Next year, they give them a one-half-percent increase. But in the next 9 years, their budget assumptions assume the doctors will take a 23-percent cut. That is absolutely bogus. We are not going to cut the doctors 23 percent. We cannot do so and maintain health care in America for our seniors. And yet, that is one of the major problems with Medicare today: we are not on a sound financial basis. This bill assumes that Medicare expenditures for physicians is going to drop 23 percent in 2011 and remain at that rate—and that amounts to a $250 billion shortfall from 2011 through 2019.

So, they ask: how can we figure out how to do this, how to make this bill

deficit-neutral and less than $900 billion? We don't want to admit that our bill is not a $130 billion surplus over 10 years if we have to pay the doctors, which we are going to pay one way or the other. If we pay the doctors, it will actually be a $120 billion deficit on that issue alone. So what can they do? They came up with a budgetary gimmick. They just took physician pay out of the health care reform package, and decided to try to pass it on the floor of the Senate, with every penny of it, $250 billion, going to the deficit—not a penny of it paid for.

So if you bring the physician pay issue back up, and add it to the health care reform bill that we are supposed to be passing, you end up at the beginning of the whole thing with a $120 billion deficit. So, to avoid that, supporters of this bill moved physician pay out of the bill and tried to pass it. A lot of the Democratic colleagues wouldn't vote for that. It failed because, out in the open before the whole world, people did not want to vote, after all of this deficit that we are imposing on our children and grandchildren, for another $250 billion hit to the debt. How can we continue to do that? So it was voted down, thank goodness. But the problem is still there. You have to raise $494 billion in taxes to make this bill deficit-neutral. Instead of using that money to fund new entitlement programs, maybe we ought to use that tax revenue to pay for the program we have: Medicare, the one that is slipping into serious default, one in which we are not paying the doctors what we should be paying them for the work they do. If we are going to raise taxes, maybe that is what we ought to do with the money—and not create a new entitlement benefit that is going to grow and far exceed costs projections in the years to come and further jeopardize our spending. As I think most of my colleagues are pretty well informed, under the present spending program we will double the entire debt of the United States of America in 5 years. Then, in 10 years, we will triple it. It will go from $5.7 trillion to over $17 trillion in 10 years. We cannot keep doing this. It is unsustainable and the American people know it.

So, the cost promises of the bill are not being met. There are a lot of other points too. I would just first mention the fact that it was contended at the beginning that this reform bill ought to be able to keep us from spending so much of our gross domestic product on health care. It is a serious matter. We definitely need to wrestle with the cost of health care. It is not an easy thing to deal with. But what does this bill do? It promised it was going to do something about that. It was going to bend the cost curve. Our cost curve on health care is currently going up, and this bill was going to bend it downward, contain the growth of health care as a percentage of the gross domestic product in America, and free up money for economic growth and jobs and other important items.

Well, does the bill do that? No, it doesn't. As Senator THUNE has pointed out, and others have, health care currently is about 17 percent of our gross domestic product. Of the total wealth of America, its productivity, 17 percent goes to providing health care. If this bill is passed, it will increase to 21 percent, and that is a faster rate of increase than if we didn't pass this bill at all. That is a big deal. I thought we had a promise and a commitment that the bill would reduce the percentage of growth there. Indeed, it will not.

There are a number of other issues that I will be talking about, including how the actual premiums for average families for insurance will be going up instead of going down as has been promised by the President and how this bill will increase the deficit and not reduce it; how it will increase the percentage of GDP to health care and not decrease it; how it will increase taxes and how it will raid Medicare, but not shore up the program. I am just going to repeat this again, because it is important: This bill is a raid on Medicare. It cannot be disputed, in my view. The idea that we could take $465 billion out of Medicare and put it into an entirely new program without having any adverse effect on Medicare is something I don't think anybody can imagine to be true.

How did they do that, you might ask. Well, Senator SESSIONS, surely they thought this through. How can they say that? This is the gimmick. This is how they do it: We are not denying any ''guaranteed'' benefits under Medicare, they say. Don't worry, seniors. All your guaranteed benefits are going to be provided. Where does the $465 billion come from? Well, we are just going to cut the providers, not your benefits. We are going to cut hospitals. We are going to cut hospice. We are going to cut home health care. We are going to cut nursing homes. We are going to cut disproportionate share hospitals that treat the poor, all of these things. We are going to cut all of these institutions and groups that provide health care, but don't worry. You will still get all of the benefits you had before. Study after study indicates that the health care providers are already operating on the margin. Health care will be savaged under this bill.

Second, if, indeed, we could save money in Medicare—and I think there are some savings there, and we need to work at it and see what we can do without breaching the promise we made to our seniors—if we could save money there, let me ask my colleagues: What would you do with the money that is saved? Would you use it to try to keep Medicare healthy, or would you create a new entitlement program with it and raid the seniors' money?

Well, that is what has happened. The savings that are from Medicare need to be kept in Medicare so that we can keep the program from going insolvent in 2017. We should use that money, those savings to help the seniors.

Remember, Medicare is funded and has been funded by people such as Bill Eberle from Huntsville, AL, who wrote me about it. He said he paid into the fund for 40 years and now he is ready to draw down benefits. He didn't get any benefit from his years of Medicare taxes until he hit 65. But now he is ready to draw, and we are considering taking his money and spending it on somebody else. He doesn't like that. He doesn't think that is right, and he is correct.

That is why I am not able to support the legislation. It doesn't do what it promised. It is going to make our health care situation worse. It is going to create greater debt at a time when our spending is already out of control.

I thank the Chair and my colleagues. I hope as this debate goes forward that we can make some improvements, although I am not confident of the direction that we are headed right now. It seems as though any significant attempt to make real progress with the bill is failing. But Senator GREGG's amendment is important. I hope my colleagues will study up on it and vote to preserve Medicare and to keep the savings that can be obtained in Medicare in the program, and not create a new entitlement.

I thank the Chair.

Mr. ENZI. Mr. President, I rise in support of Senator JUDD GREGG'S amendment, which would prevent the Medicare cuts in the Reid bill from being used to pay to create a new entitlement program to cover the uninsured.

I do not oppose covering the uninsured. Nor do I oppose reforming the Medicare Program. We should do those things.

What I oppose is the Reid bill. This is the wrong approach to solve these problems.

The amendment offered by my friend from New Hampshire highlights the main problems with the Reid bill and suggests a better approach.

His amendment would protect the savings from the Medicare Program, and prevent them from being used to create a new entitlement.

This would mean that this new program would not have to rely on cuts to Medicare to fund its operation. It would also reserve all of the money taken from Medicare so that it could be used to fix the problems in the Medicare Program.

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

That means that, as Federal spending continues to grow, this new program will continue to grow. It will crowd out other federal spending priorities, like education and national defense.

Any future attempts to modify or restrain its growth will be met by cries

of indignation, arguing that cuts would devastate access to health care. If anyone has any doubts, they should look at the transcripts from our debate on the Deficit Reduction Act.

In 2005, Congress tried to reduce Medicare spending by about $20 billion and enact modest reforms to the Medicaid Program. These programs would have strengthened the long-term solvency of these programs and helped reduce the Federal deficit.

In response, Senator REID called that bill an ''immoral document.'' The junior Senator from California said she strongly opposed the cuts in the bill, because they would ''cut Medicare and Medicaid by $27 billion.''

Yet today, these same Members and the rest of my Democratic colleagues want to create a new entitlement program that will spend hundreds of billions of dollars. And they would pay for it by cutting $464 billion from the Medicare Program.

I believe these facts highlight why we need to adopt the Gregg amendment. I don't believe we should create a new entitlement program, which will permanently obligate our children and grandchildren to pay its costs. If my colleagues insist on doing it, however, at a minimum we need to guarantee that any new program has a stable and reliable source of funding.

The Medicare cuts in this bill are neither stable nor reliable.

My Democratic colleagues have spoken at length about how the Medicare provisions in this bill will bend the growth of heath care spending. That is unfortunately far from accurate.

If you don't believe me, listen to what other nationally recognized experts have to say.

According to the New York Times, the CEO of the world renowned Mayo Clinic dismissed the reforms in the bill. Dennis Cortese said the Reid bill only took baby steps towards revamping the current fee-for-service system.

The dean of the Harvard Medical School, Jeffery Flier, said that the bills being considered in Congress would accelerate national health care spending.

I wish there were more actual reforms in this bill. I applaud some of the efforts that Senator BAUCUS included that will create incentives for coordinated care and rewarding providers who provide higher quality. I believe those are exactly the types of things that we should be doing to improve the Medicare Program.

Unfortunately, the savings from these actual reforms are a few pennies compared to the dollars of arbitrary payment cuts included in this bill.

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

In contrast, the Reid bill includes over $220 billion in arbitrary payment cuts to health care providers, including hospitals, nursing homes, home health agencies and hospice providers. The Reid bill also includes an additional $120 billion in cuts to Medicare Advantage plans.

Those are not reforms. Instead they represent the best efforts of folks in Washington to guess how much it actually costs real doctors and nurses to provide health care services to Medicare beneficiaries.

These cuts are an excellent example of how government price controls work.

Medicare does not negotiate payment rates with providers, like private insurers. Medicare uses price controls to set payment rates. Experts in Washington then look at various reported costs, revenues and profits of health care providers and then decide how much we should pay health care providers.

I have often said that everyone thinks they know everything about a business, until they actually have to run it. As a former small business owner, I want to assure them, it is actually a lot harder than it looks.

The Medicare cuts in this bill are based on the efforts of folks in Washington to decide how much it costs to run a nursing home in Cheyenne or a home health agency in Gillette. Based on their past track record, I don't have much confidence in their abilities.

In 1997, Congress passed the Balanced Budget Act. It contained over $434 billion in Medicare payment cuts. Lots of really smart folks in Washington made arguments similar to those we are hearing today about how these cuts would not harm providers or beneficiaries.

What happened after these cuts went into effect? Within two years, these cuts had driven four of the largest nursing home chains in the Nation into bankruptcy.

Vencor, Sun Healthcare, Integrated Health Services and Mariner Post-Acute Network all filed for bankruptcy. Between them, they operated 1,400 nursing homes that provided care for hundreds of thousands of Medicare beneficiaries.

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

Given this track record, I have grave concerns about what the Medicare cuts in the Reid bill would do to Medicare beneficiaries and the doctors, hospitals and other providers who treat them.

I have even greater concerns about using any estimated savings from these cuts to fund this new entitlement program for the uninsured.

That is why we should pass the Gregg amendment. Rather than relying on cuts that could devastate the Medicare Program, let's find a stable and reliable funding source that we could use to pay for health care reform.

The Gregg amendment says that savings from any Medicare cuts should be reserved for the Medicare Program. That way, if the Washington experts again got it wrong, we will not have already spent all the savings on another program.

Mr. INHOFE. Mr. President, yesterday the U.S. Senate voted on two measures, one by the Senator from Massachusetts and one by the Senator from Nebraska relating to home health benefits. I was unable to attend yesterday's session of the Senate but had I voted, I would have voted for both measures.

Home health and hospice benefits are very important to Oklahomans. In fact, the National Association for Home Care and Hospice reported that Oklahomans alone may receive a cut of over $1 billion in home health and hospice benefits under this bill. I understand the value of home health and hospice very well. In March 2007, I introduced legislation with Senators THAD COCHRAN, ROGER WICKER, PETE DOMENICI, and RICHARD SHELBY, the Preserving Access to Hospice Act, to ensure America's terminally ill seniors have access to hospice care, by providing immediate relief for hospices impacted by the Medicare hospice cap and authorizing a MedPAC study on the cap issue. Identical legislation was introduced in the House led by Congressman JOHN SULLIVAN with many cosponsors. I introduced this legislation because of a flawed provision in Federal law which required hospices to repay the Centers for Medicare and Medicaid Services, CMS, for serving eligible patients in prior years. Many small, family, and community-owned hospices faced closure, and patients faced losing access to hospice care. In Oklahoma especially, hospice care companies of all sizes service a large number of Oklahomans. However, in 2005, 41 percent of the hospices providing care in Oklahoma received letters from CMS demanding repayment. Since then, I have been working to help small, community hospices in Oklahoma as they face repayment letters from CMS for millions of dollars. Without help, hospices face closure and the discharge of significant numbers of terminally ill patients, possibly into more expensive care. In fact, during last summer's contentious debate on physician Medicare reimbursements, I argued at the very least for a MedPAC study on payment methodology for hospice care to evaluate if there is a problem with payments and whether cap amount revisions are needed.

I understand and greatly appreciate the value of good home health care and hospice benefits.

Admittedly, one of the measures considered yesterday would have been better than the other. The amendment from the Senator from Massachusetts simply said that nothing in the bill should result in the reduction of guaranteed home health benefits. The problem is that access to home health is

not a ''guaranteed'' Medicare benefit. So even though the amendment from the Senator from Massachusetts passed 96 to 0, will it have a real impact on protecting seniors from the loss of access to home health care? No. The better approach was offered by the Senator from Nebraska. Unfortunately, the better approaches are failing by party line votes. However, I compliment the Senator from Virginia, Mr. WEBB, for his support of the motion by the Senator from Nebraska. This motion would have recommitted this entire legislation to the appropriate Senate committee to remove the cuts to home health benefits. I think that is the best and most direct approach. I think that is the most honest approach. Simply remove the cuts. For the past several days we have been discussing the cuts to Medicare and especially the cuts to Medicare Advantage. In each case, the Republicans have offered motions and amendments to recommit this massive 2,000-page health bill back to committee to improve it, namely, to remove the cuts to programs seniors and the disabled use. I was disappointed to see this most recent attempt to send this massive bill back to committee to improve it fail 41 to 53.

I look forward to today's debate. One scheduled for a vote is on medical malpractice reform. It will be very interesting to see just how serious the Democrats are about health care reform. Currently, the bill only has a ''sense of the Senate'' recognizing medical malpractice costs are a problem. We'll see if they think it is important to really do anything about it.

MORNING BUSINESS

Mr. BEGICH. Mr. 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 COSPONSORS

S. 1389

At the request of Mr. NELSON of Nebraska, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 1389, a bill to clarify the exemption for certain annuity contracts and insurance policies from Federal regulation under the Securities Act of 1933.

AMENDMENT NO. 2884

At the request of Ms. STABENOW, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of amendment No. 2884 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2927

At the request of Mrs. HUTCHISON, her name was added as a cosponsor of amendment No. 2927 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2939

At the request of Mr. PRYOR, the names of the Senator from Iowa (Mr. HARKIN) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of amendment No. 2939 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2940. Mr. SPECTER (for himself, Mr. MERKLEY, Mr. WYDEN, Mr. CASEY, Ms. STABENOW, Mr. LEVIN, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2941. Mr. SPECTER (for himself, Mr. WYDEN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2942. Mr. GREGG (for himself, Mr. CORKER, Mr. THUNE, Mr. COBURN, Mr. ENSIGN, Mr. ISAKSON, Mr. BURR, Mr. ENZI, Mr. ALEXANDER, Mr. BARRASSO, Mr. CORNYN, Mr. MCCAIN, and Mr. LEMIEUX) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2943. Mr. CARPER (for himself and Mr. CONRAD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2944. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2945. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2946. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2947. Ms. KLOBUCHAR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2948. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2949. Mr. ROCKEFELLER (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2950. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2951. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2952. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2940. Mr. SPECTER (for himself, Mr. MERKLEY, Mr. WYDEN, Mr. CASEY, Ms. STABENOW, Mr. LEVIN, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 466, between lines 5 and 6, insert the following:

SEC. 2305. EXTENSION OF DELAY IN APPLICATION OF MEDICAID PROVIDER TAX PROVISIONS TO CERTAIN MANAGED CARE ORGANIZATIONS.

Effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171), section 6051(b)(2)(A) of that Act of 2005 42 U.S.C. 1396b note) is amended by striking ''2009'' and inserting ''2011''.

SA 2941. Mr. SPECTER (for himself, Mr. WYDEN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 857, strike lines 5 through 25 and insert the following:

(a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(1) by inserting ''complex rehabilitative power-driven wheelchair and any other'' after ''in the case of a'' and

(2) by adding at the end the following: ''In the case of a power-driven wheelchair that is

not a complex rehabilitative power-driven wheelchair, the following rules shall apply:

''(aa) The first sentence of this clause shall only apply if the length of need is at least 13 months, as certified by a physician.

''(bb) If the individual exercises the option under the first sentence of this clause and the individual discontinues use of the item prior to end of the 13-month period that begins on the date the individual exercises such option, the supplier shall be subject to recovery by the Secretary of an amount equal to the amount (if any) by which the lump-sum payment for the purchase for the wheelchair exceeds the total of the monthly payments for the wheelchair that would have been made on a rental basis for continuous use of less than 13 months.

''(cc) If the Secretary recovers any payments under item (bb), the title for the wheelchair shall revert to the supplier at the option of the supplier.''.

SA 2942. Mr. GREGG (for himself, Mr. CORKER, Mr. THUNE, Mr. COBURN, Mr. ENSIGN, Mr. ISAKSON, Mr. BURR, Mr. ENZI, Mr. ALEXANDER, Mr. BARRASSO, Mr. CORNYN, Mr. MCCAIN, and Mr. LEMIEUX) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. _____. PREVENTING THE IMPLEMENTATION OF NEW ENTITLEMENTS THAT WOULD RAID MEDICARE.

(a) BAN ON NEW SPENDING TAKING EFFECT.—

(1) PURPOSE.—The purpose of this section is to require that savings resulting from this Act must fully offset the increase in Federal spending and reductions in revenues resulting from this Act before any such Federal spending increases or revenue reductions can occur.

(2) IN GENERAL.—Notwithstanding any other provision of this Act, the Secretary of the Treasury and the Secretary of Health and Human Service are prohibited from implementing the provisions of, and amendments made by, sections 1401, 1402, 2001, and 2101, or any other spending increase or revenue reduction provision in this Act until both the Director of the Office of Management and Budget (referred to in this section as ''OMB'') and the Chief Actuary of the Centers for Medicare and Medicaid Services Office of the Actuary (referred to in this section as'' CMS OACT'') each certify that they project that all of the projected Federal spending increases and revenue reductions resulting from this Act will be offset by projected savings from this Act.

(3) CALCULATIONS.—For purposes of this section, projected savings shall exclude any projected savings or other offsets directly resulting from changes to Medicare and Social Security made by this Act.

(b) LIMIT ON FUTURE SPENDING.—On September 1 of each year (beginning with 2013), the CMS OACT and the OMB shall each issue an annual report that—

(1) certifies whether all of the projected Federal spending increases and revenue reductions resulting from this Act, starting with the next fiscal year and for the following 9 fiscal years, are fully offset by projected savings resulting from this Act (as calculated under subsection (a)); and

(2) provides detailed estimates of such spending increases, revenue reductions, and savings, year by year, program by program and provision by provision.

SA 2943. Mr. CARPER (for himself and Mr. CONRAD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 722, after line 20, insert the following:

SEC. 3016. ADVANCING IMPLEMENTATION OF CERTAIN VALUE-BASED PURCHASING PROGRAMS.

(a) ADVANCING IMPLEMENTATION OF HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

(1) IN GENERAL.—Section 1886(o) of the Social Security Act, as added by section 3001, is amended—

(A) in paragraph (1)(B—

(i) in the subparagraph heading, by striking ''2013'' and inserting ''2012''; and

(ii) by striking ''2012'' and inserting ''2011'';

(B) in paragraph (2)(B)—

(i) in clause (i), by striking ''2013'' each place it appears and inserting ''2012''; and

(ii) in clause (ii), by striking ''2014'' and inserting ''2013''; and

(C) in paragraph (7)—

(i) in subparagraph (B)(i), by striking ''2013'' and inserting ''2012'';

(ii) in subparagraph (C)—

(I) in clause (i), by striking ''2013'' and inserting ''2012'';

(II) in clause (ii), by striking ''2014'' and inserting ''2013'';

(III) in clause (iii), by striking ''2015'' and inserting ''2014'';

(IV) in clause (iv), by striking ''2016'' and inserting ''2015''; and

(V) in clause (v), by striking ''2017'' and inserting ''2016''; and

(iii) in subparagraph (D)(ii)(I), by striking ''2012 and 2013'' and inserting ''2011, 2012, and 2013''.

(2) CONFORMING AMENDMENT.—Section 1886(b)(3)(B)(viii) of the Social Security Act, as amended by section 3001, is further amended—

(A) in subclause (V), by striking ''2012'' and inserting ''2011''; and

(B) in each of subclauses (VIII) and (IX), by striking ''2013'' each place it appears and inserting ''2012''.

(b) ADVANCING IMPLEMENTATION OF NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.—Section 1866D(a)(3) of the Social Security Act, as added by section 3023, is amended by striking ''2013'' and inserting ''2012''.

SEC. 3017. INTEGRATED HEALTH CARE SYSTEM COLLABORATION INITIATIVE.

(a) IN GENERAL.—In order to improve health care quality and reduce costs, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop, in consultation with major integrated health systems that have consistently demonstrated high quality and low cost (as determined by the Secretary and verified by a third party) a collaboration initiative (referred to in this section as ''the Collaborative''). The Collaborative shall develop an exportable model of optimal health care delivery to apply value-based measurement, integrated information technology infrastructure, standard care pathways, and population-based payment models, to measurably improve health care quality, outcomes, and patient satisfaction and achieve cost savings.

(b) PARTICIPATION.—Prior to January 1, 2010, the Secretary shall determine 5 initial participants who will form the Collaborative and at least 6 additional participants who will join the Collaborative beginning in the fourth year that the Collaborative is in effect.

(1) INITIAL PARTICIPANTS.—Initial participants selected by the Secretary shall meet the following criteria:

(A) Be integrated health systems organized for the purpose of providing health care services.

(B) Have demonstrated a record of providing high value health care for at least the 5 previous years, as determined by the Secretary in accordance with the Dartmouth Atlas of Health Care.

(C) Any additional criteria specified by the Secretary.

(2) ADDITIONAL PARTICIPANTS.—Beginning January 1, 2013, the Secretary shall select 6 or more additional participants who represent diverse geographic areas and are situated in areas of differing population densities who agree to comply with the guidelines, processes, and requirements set forth for the Collaborative. Such additional participants shall meet the following additional criteria:

(A) Be organized for the provision of patient medical care.

(B) Be capable of implementing infrastructure and health care delivery modifications necessary to enhance health care quality and efficiency, as determined by the Secretary in accordance with the Dartmouth Atlas of Health Care.

(C) The participant's cost and intensity of care do not meet the definition of high value health care.

(3) ADDITIONAL CRITERIA.—In addition to the criteria described in paragraphs (1) and (2), the participants in the Collaborative shall meet the following criteria:

(A) Have a legal structure that would allow the participant to receive incentive payments under this section.

(B) Agree to report on quality, cost, and efficiency in such form, manner, and frequency as specified by the Secretary.

(C) Provide care to patients enrolled in the Medicare program.

(D) Agree to contribute to a best practices network and website, that is maintained by the Collaborative for sharing strategies on quality improvement, care coordination, efficiency, and effectiveness.

(E) Use patient-centered processes of care, including those that emphasize patient and caregiver involvement in shared decision-making for treatment decisions.

(F) Meet other criteria determined to be appropriate by the Secretary.

(c) COLLABORATIVE INITIATIVE.—

(1) IN GENERAL.—Beginning January 1, 2010, the Collaborative shall begin a 2 year development phase in which initial participants share the quantitative and qualitative methods through which they have developed high value health care followed by a dissemination of that learning model to additional participants of the Collaborative.

(2) COORDINATING MEMBER.—In consultation with the Secretary, the Collaborative shall select a coordinating member organization (hereafter identified as the Coordinating Organization) of the Collaborative.

(3) QUALIFICATIONS.—The Coordinating Organization will have in place a comprehensive Medicare database and possess experience using and analyzing Medicare data to

measure health care utilization, cost, and variation, such as The Dartmouth Institute for Health Policy and Clinical Practice. The Coordinating Organization shall be responsible for reporting to the Secretary as required and for any other requirements deemed necessary by the Secretary.

(4) RESPONSIBILITIES.—The Coordinating Member shall—

(A) lead efforts to develop each aspect of the learning model;

(B) organize efforts to disseminate the learning model for high value health care, including educating participant institutions; and

(C) provide administrative, technical, accounting, reporting, organizational and infrastructure support needed to carry out the goals of the Collaborative.

(5) DEVELOPMENT OF LEARNING MODEL.—

(A) IN GENERAL.—Initial participants in the Collaborative shall work together to develop a learning model based on their experience that includes a reliance on evidence based care that emphasizes quality and practice techniques that emphasize efficiency, joint development and implementation of health information technology, introduction of clinical microsystems of care, shared decision-making, outcomes and measurement, and the establishment of an e-learning distributive network, which have been put into practice at their respective institutions.

(B) RESPONSIBILITIES.—The Coordinating Member shall do the following:

(i) Partner with initial participants to comprehensively understand each institution's contribution to providing value-based health care.

(ii) Provide and measure value-based health care in a manner that ensures that measures are aligned with current measures approved by a consensus-based organization, such as the National Quality Forum, or other measures as determined appropriate by the Secretary, while also incorporating patient self-reported status and outcomes.

(iii) Create a replicable and scalable infrastructure for common measurement of value-based care that can be broadly disseminated across the Collaborative and other institutions.

(iv) Implement care pathways for common conditions using standard measures for assessment across institutions, targeting high variation and high cost conditions, including but not limited to—

(I) acute myocardial infarction (AMI) and angioplasty;

(II) coronary artery bypass graft surgery and percutaneous coronary intervention;

(III) hip or knee replacement;

(IV) spinal surgery; and

(V) care for chronic diseases including, but not limited to, diabetes, heart disease, and high blood pressure.

(v) Deploy and disseminate the comprehensive learning model across initial participant institutions, achieving improvements in care delivery and lowering costs, and demonstrating the portability and viability of the processes.

(6) ADDITIONAL BEST PRACTICES.—As additional methods of improving health care quality and efficiency are identified by members of the Collaborative or by other institutions, Initial Participants in the Collaborative shall incorporate those practices into the learning model.

(d) IMPLEMENTATION OF LEARNING MODEL.—

(1) IN GENERAL.—Beginning January 1, 2013, as additional participants are selected by the Secretary, Initial Participants in the Collaborative shall actively engage in the deployment of the learning model to educate each additional participant in the common conditions that have been identified.

(A) DISSEMINATION OF LEARNING MODEL.—Dissemination methods shall include but not be limited to the following methods:

(i) Specialized teams deployed by the Initial Participants to teach and facilitate implementation on site.

(ii) Distance-learning, taking advantage of latest interactive technologies.

(iii) On-line, fully accessible repositories of shared learning and information related to best practices.

(iv) Advanced population health information technology models.

(B) EVALUATION OF PARTICIPANTS.—Evaluation of initial participants shall be based on documented success in meeting quality and efficiency targets. Specific statistically valid measures of evaluation shall be determined by the Secretary.

(e) EFFICIENCY AND QUALITY TARGETS.—

(1) EFFICIENCY TARGET BASED ON GROWTH RATE.—Initial participants shall implement techniques under the comprehensive learning model to meet a growth rate target equal to, as selected by the Secretary with respect to the participant—

(A) the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year, plus 2 percentage points; or

(B) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year, minus 1.5 percentage points.

(2) QUALITY TARGET.—The Secretary shall establish a quality target, based on measures endorsed by a consensus-based quality organization, for the initial participants in the first year and subsequently for the additional participants.

(f) PAYMENTS.—

(1) BASE PAYMENT.—With respect to each participant in the Collaborative, the Secretary shall determine a base amount on a per capita basis for the participant for purposes of measuring the growth rate in total payments for common conditions, based on the reimbursement amount paid to the participant under title XVIII of the Social Security Act for furnishing items and services with respect to such conditions.

(2) BONUS PAYMENT.—If the growth rate in total payments for services for common conditions does not exceed the growth rate target selected for the participant under subsection (e)(1), and the participant satisfies the quality target established by the Secretary under subsection (e)(2), the Secretary shall provide a bonus payment equal to 50 percent of any per capita payment reductions that are below the capita base amounts determined under paragraph (1).

(3) PENALTY PAYMENT.—If the growth rate in total per capita payments for furnishing items and services for common conditions exceeds the growth rate target, the Secretary shall pay only 25 percent of any additional expenses that exceed the base amounts determined under paragraph (1).

(4) BUDGET NEUTRALITY LIMITATION.—The Secretary shall limit incentive payments to each of the participating organizations under this section as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries under title XVIII of the Social Security Act (inclusive of incentive payments described in this subsection) do not exceed the amount that the Secretary estimates would be expended for such beneficiaries if the Collaborative under this section were not implemented.

(g) ADMINISTRATIVE PAYMENT.—Out of funds not otherwise obligated in the Treasury, there are appropriated $228,000,000, to remain available until expended, to be distributed in the following manner:

(1) The Coordinating Organization shall receive $10,000,000 per year for program development related to the Collaborative, including for health information technology and other infrastructure, project evaluations, analysis, and measurement, compliance, auditings and other reporting. Not less than $5,000,000 of such funds shall be provided for education and training, including for support for the establishment of training teams for the Collaborative, to assist in the integration of new health information technology, best practices of care delivery, microsystems of care delivery, and a distributive e-learning network for the Collaborative.

(2) Each Initial Participant shall receive $4,000,000 per year for internal program development for health information technology and other infrastructure, education and training, project evaluations, analysis, and measurement, and compliance, auditing, and other reporting.

(3) Beginning in 2013, the Secretary may provide funding to additional participants in the Collaborative in an amount not to exceed $4,000,000 per participant per year under the same use guidelines as apply to the Initial Participants.

(h) CONTINUATION OR EXPANSION.—

(1) TERMINATION.—Subject to paragraph (2), the Collaborative shall terminate on the date that is 6 years after the date on which the Collaborative is established.

(2) EXPANSION.—The Secretary may continue or expand the Collaborative if—

(A) participants meet the established growth rate targets and consistently receive bonus payments during the first 4 years of the Collaborative and are consistently meeting quality standards; or

(B) the Collaborative is consistently exceeding quality standards and is not increasing spending under the program.

(i) TERMINATION.—The Secretary may terminate an agreement with the Collaborative or a participating organization under the Collaborative if such organization did not qualify for incentive payments or consistently failed to meet quality standards in any of the first 3 years of the Collaborative.

(j) REPORTS.—

(1) PERFORMANCE RESULTS REPORTS.—The Secretary shall provide such data as is necessary for the Collaborative to measure the efficacy of the Collaborative and facilitate regular reporting on spending and cost savings results relative to a value-based program initiative.

(2) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and annually thereafter, the Secretary shall submit to Congress and make publicly available a report on the authority granted to the Secretary to carry out the Collaborative under this section. Each report shall address the impact of the use of such authority on expenditures for, access to, and quality of, care under title XVIII of the Social Security Act.

(k) DEFINITIONS.—In this section:

(1) BENEFICIARY.—The term ''beneficiary'' means a Medicare beneficiary enrolled under part B and entitled to benefits under part A who is not enrolled in Medicare Advantage under Part C or a PACE program under section 1894, and meets other criteria as the Secretary determines appropriate.

(2) HIGH VALUE HEALTH CARE.—The term ''high value health care'' means the care delivered by organizations shown by statistically valid methods to meet the highest quality measures established by the Secretary as of or after the date of enactment of this Act and to be delivering low-cost care

with high patient satisfaction and clinical outcomes.

(3) LEARNING MODEL.—The term ''learning model'' means a standardized model developed by the Initial Participants in the Collaborative and based on best practices, as jointly developed and put into practice at the Initial Participant's respective institutions.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(l) ADDITIONAL MONITORING.—The Secretary may monitor data on expenditures and quality of services under title XVIII of the Social Security Act with respect to a beneficiary after the beneficiary discontinues receiving services under the Collaborative.

(m) OTHER PROVISIONS.—

(1) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under this section or otherwise of—

(A) the elements, parameters, scope, and duration of the Collaborative, including the selection of participants in the Collaborative;

(B) the establishment of targets, measurement of performance;

(C) determinations with respect to whether savings have been achieved and the amount of savings;

(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

(E) decisions about the extension or expansion of the Collaborative.

(2) ADMINISTRATION.—Chapter 35 of title 44, 4 United States Code shall not apply to this section.

(3) EVALUATION.—The Secretary shall evaluate the payment incentive model for the Collaborative to assess impacts on beneficiaries and on the Medicare program under title XVIII of the Social Security Act. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

(4) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of the Collaborative with regard to violations of section 1877 of the Social Security Act (popularly known as the ''Stark law'').

(5) ANTI-DISCRIMINATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the Collaborative, or with an entity to administer the Collaborative, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the Collaborative for beneficiaries to participate in the Collaborative, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

SA 2944. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, add the following:

SEC. 5316. GERIATRIC HEALTH CARE WORKFORCE.

(a) INVESTMENT IN TOMORROW'S GERIATRIC HEALTH CARE WORKFORCE.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5314, is further amended by adding at the end the following:

''SEC. 779. INVESTMENT IN TOMORROW'S GERIATRIC HEALTH CARE WORKFORCE.

''(a) ESTABLISHMENT.—The Secretary shall establish and carry out a Geriatric and Gerontology Loan Repayment Program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) as a physician, physician assistant, nurse practitioner, clinical nurse specialist, pharmacist, psychologist, physical therapist, or social worker in geriatric care practice.

''(b) PROGRAM ADMINISTRATION.—Under the program established under subsection (a), the Secretary shall enter into contracts with qualified health professionals described in subsection (c) under which—

''(1) such qualified health professionals agree to provide full-time clinical practice and service to older adults through work serving, or for a provider serving—

''(A) an area with shortage of the specified geriatric or gerontology specialty that has a sufficient population of older adults to support such geriatric or gerontology speciality, as determined by the Secretary; and

''(B) a medically underserved community (including a health professional shortage area), or a medically underserved population; and

''(2) the Secretary agrees to make payments on the principal and interest of the graduate medical education loans of professionals described in paragraph (1) that—

''(A) are not more than $35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 4 years; and

''(B) are not more than 1/4 of the total of such principal and interest, for each year of the service, for a period of not more than 4 years.

''(c) QUALIFIED HEALTH PROFESSIONALS.—

''(1) IN GENERAL.—A qualified health professional described in this subsection is an individual—

''(A) who—

''(i) is a physician, including an osteopathic physician, who—

''(I) is entering or enrolled in an accredited fellowship in geriatric medicine or geriatric psychiatry; or

''(II) has completed (but not prior to the calendar year in which this section is enacted) an accredited fellowship in geriatric medicine or geriatric psychiatry; or

''(ii) is a nurse practitioner or clinical nurse specialist, pharmacist, social worker, physician assistant, physical therapist, or psychologist who has completed specialty training in geriatrics or gerontology;

''(B) who has obtained an educational loan for costs associated with graduate training in medicine, pharmacy, psychology, physical therapy, or social work, or costs associated with training to become a nurse practitioner, clinical nurse specialist, or physician assistant;

''(C) who is appropriately licensed or certified in the State in which the individual practices, or who meets other qualifications as determined by the Secretary;

''(D) who agrees to provide clinical services to older adults for a period of not less than 2 years in a setting determined appropriate by the Secretary; and

''(E) who has demonstrated the capability through education or training to work with frail older adults and older adults with disabilities, including individuals with dementia, urinary incontinence, and problems with balance or mobility, and medication regimes for older adults.

''(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an individual unless—

''(A) the individual is a United States citizen or a permanent legal United States resident;

''(B) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary); and

''(C) the individual is not participating in any other Federal undergraduate or graduate medical education loan repayment program.

''(d) PRIORITY.—In entering into contracts under this section, the Secretary shall give priority to qualified health professionals who demonstrate financial need.

''(e) APPLICABILITY OF CERTAIN PROVISIONS.—With respect to the National Health Service Corps Loan Repayment Program established in subpart III of part D of title III, the provisions of such subpart shall, except as inconsistent with this section, apply to the program established in this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program.

''(f) DEFINITION.—In this section:

''(1) GERIATRICS.—The term 'geriatrics' means the branch of medicine that deals with the problems and diseases of older adults and aging, including chronic conditions and geriatric syndromes such as dementia, delirium, urinary incontinence, osteoporosis, falls or gait disorders, or sleep disorders.

''(2) GERONTOLOGY.—The term 'gerontology' means the interdisciplinary study of the aging process and individuals as they grow from middle age through later life. Such term encompasses the social, cognitive, psychological, biological, and economic aspects of aging.

''(3) GRADUATE MEDICAL EDUCATION.—The term 'graduate medical education' means a graduate program in medicine, pharmacy, psychology, physical therapy, or social work, or a graduate program that trains individuals to become nurse practitioners, clinical nurse specialists, or physician assistants.

''(4) SPECIALTY TRAINING.—The term 'specialty training' means a concentration in coursework in geriatrics or gerontology or clinical training, including internships, residency programs, or fellowships, in a geriatric setting, or other requirements, as determined by the Secretary.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $4,000,000 for fiscal year 2010, $9,500,000 for fiscal year 2011, $16,000,000 for fiscal year 2012, $24,000,000 for fiscal year 2013, and $30,500,000 for fiscal year 2014.''.

(b) EXPANSION OF NURSING EDUCATION LOAN REPAYMENT PROGRAM.—Section 846 of the Public Health Service Act (42 U.S.C. 297n) is amended—

(1) by redesignating subsection (i) as subsection (j); and

(2) by inserting after subsection (h), the following:

''(i) GERIATRIC CARE PRACTICE IN LONG-TERM CARE SETTINGS.—

''(1) LOAN REPAYMENTS.—In providing for loan repayments under this section, the Secretary shall ensure that eligible individuals include registered nurses who complete specialty training in geriatrics or gerontology and who elect to provide nursing services to older adults in home and community-based or facility-based long-term care settings, or any other program determined appropriate by the Secretary.

''(2) DEFINITION.—In this subsection, the term 'specialty training' means coursework in geriatrics or gerontology or clinical training, including internships or fellowships, in a geriatric setting.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $1,500,000 for fiscal year 2010, $3,000,000 for fiscal year 2011, $5,000,000 for fiscal year 2012, $7,000,000 for fiscal year 2013, and $8,500,000 for fiscal year 2014.''.

SA 2945. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. REPORT ON IMPACT OF NURSE STAFFING.

Not later than 18 months after the date of the enactment of this Act, the Director of the Agency for Healthcare Research and Quality shall submit to Congress a report on the impact of the nurse-to-patient ratio on the quality of care and patient outcomes, including recommendations for further integration into quality measurement and quality improvement activities as determined appropriate.

SA 2946. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 330, line 9, insert after ''1402(g)(1)'' the following: '', or an individual who would be eligible for an exemption under such section if the individual were self-employed,''.

SA 2947. Ms. KLOBUCHAR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1411, between lines 5 and 6, insert the following:

SEC. 5316. GRANTS FOR EMERGENCY MEDICAL SERVICES PERSONNEL TRAINING FOR VETERANS.

Section 330J of the Public Health Service Act (42 U.S.C. 254c–15) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (E), by striking ''or'' at the end;

(B) by redesignating subparagraph (F) as subparagraph (G); and

(C) by inserting after subparagraph (E), the following:

''(F) an entity providing training for emergency medical services personnel, including institutions of higher education, technical colleges, community colleges, and other State-certified training entities; or''; and

(2) in subsection (c)—

(A) in paragraph (7), by striking ''and'' at the end;

(B) in paragraph (8), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(9) provide to military veterans required coursework and training that take into account, and are not duplicative of, previous medical coursework and training received when such veterans were active members of the Armed Forces, to enable such veterans to satisfy emergency medical services personnel certification requirements, as determined by the appropriate State regulatory entity.''.

SA 2948. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike subtitle I of title VI and insert the following:

Subtitle I—State Medical Malpractice Programs

SEC. 6801. PRE-LITIGATION SCREENING AND MEDIATION PANELS.

(a) IN GENERAL.—As a condition for receiving Federal funds under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), each State and territory shall, not later than 3 years after the date of enactment of this Act, create a pre-litigation screening and mediation panel which shall provide timely review of each medical malpractice claim before such claim is filed in a State or Federal court in such State.

(b) REQUIREMENTS.—

(1) IN GENERAL.—Each medical malpractice claim shall be heard by such panel before such claim may be filed in a State or Federal court and before litigation of such case may commence.

(2) REPORTS.—The panel shall issue a report containing the findings and recommendations of such panel, based on the evidence presented to the panel. The report described in this paragraph shall not affect a claimant's right to bring a medical malpractice claim in State or Federal court. Notwithstanding any other provision of State or Federal law, such report may be admissible in such court.

(c) DUTIES.—Each panel established under subsection (a) shall—

(1) review medical malpractice claims;

(2) assess the evidence offered by the parties; and

(3) render professional judgment on the validity of claims.

(d) MEMBERSHIP.—Each panel established under subsection (a) shall be comprised of lawyers, retired judges, doctors, and medical professionals. Members of the panel shall serve on a volunteer basis, unless a State chooses to arrange for compensation of, or reimbursement of expenses for, such members.

(e) EXEMPTED STATES.—A State that, on the day before the date of enactment of this Act, has enacted laws that require medical malpractice claims to be heard by a pre-litigation panel, in a manner similar to the requirements of this section, may, at the discretion of the Secretary, be exempt from the requirements of this section for as long as such State maintains such panel.

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to interfere with or restrict an individual's right to bring a lawsuit in civil courts.

SEC. 6802. STANDARDS FOR MEDICAL LIABILITY EXPERT WITNESSES.

As a condition for receiving Federal funds under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), each State and territory shall require that an individual wishing to present evidence through an expert witness in a medical malpractice case demonstrate that such expert witness—

(1) be credentialed or licensed in one or more States to deliver health care services;

(2) typically treat the diagnosis or condition at issue in the case, or provide the type of treatment under review; and

(3) is substantially familiar with applicable standards of care and practice as they relate to the act or omission that is the subject of the lawsuit.

SEC. 6803. ENCOURAGING SETTLEMENT OF MEDICAL MALPRACTICE LAWSUITS.

As a condition for receiving Federal funds under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), each State and territory shall require that a party in a medical malpractice lawsuit that refuses a settlement offer in an amount that is significantly greater than the amount awarded by a jury after trial reimburse the party that made such settlement offer for the costs of the trial, including attorney's fees associated with the trial.

SA 2949. Mr. ROCKEFELLER (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 8 and all that follows through page 200, line 5, and insert the following:

SEC. 1323. CONSUMERS CHOICE HEALTH PLAN.

(a) FINDINGS.—Congress makes the following findings:

(1) Americans need health care coverage that is always affordable.

(2) Americans need health care coverage that is always adequate.

(3) Americans need health care coverage that is always accountable.

(4) A public health insurance plan option that can compete with private insurance plans is the only way to guarantee that all consumers have affordable, adequate, and accountable options available in the insurance marketplace.

(b) OFFICE OF HEALTH PLAN MANAGEMENT.—

(1) ESTABLISHMENT.—Not later than July 1, 2010, there shall be established within the Department of Health and Human Services an Office of Health Plan Management (referred to in this section as the ''Office''). The Office shall be headed by a Director (referred to in this section as the ''Director'') who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) COMPENSATION.—The Director shall be paid at the annual rate of pay for a position at level II of the Executive Schedule under section 5313 of title 5, United States Code.

(3) LIMITATION.—Neither the Director nor the Office shall participate in the administration of the Exchanges established under

this title or the promulgation or administration of any regulation regarding the health insurance industry.

(4) PERSONNEL AND OPERATIONS AUTHORITY.—The Director shall have the same general authorities with respect to personnel and operations of the Office as the heads of other agencies and departments of the Federal Government have with respect to such agencies and departments.

(c) CONSUMER CHOICE HEALTH PLAN.—

(1) IN GENERAL.—The Office shall establish and administer the Consumer Choice Health Plan (referred to in this section as the ''Plan'') to provide for health insurance coverage that is made available to all eligible individuals (as described in paragraph (4)(A)) in the United States and its territories.

(2) REGULATORY COMPLIANCE.—The Plan shall comply with—

(A) all regulations and requirements that are applicable with respect to other qualified health plans that are offered through the Exchanges; and

(B) any additional regulations and requirements, as determined by the Director.

(3) BENEFITS.—

(A) IN GENERAL.—The Plan shall offer health insurance coverage at different benefit levels, provided that such benefits are commensurate with the required benefit levels to be provided by a qualified health plan through the Exchanges.

(B) MINIMUM BENEFITS FOR CHILDREN.—

(i) IN GENERAL.—The minimum benefit level available under the Plan for children shall include at least the services described in the most recently published version of the ''Maternal and Child Health Plan Benefit Model'' developed by the National Business Group on Health.

(ii) AMENDMENT OF BENEFIT LEVEL.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, may amend the benefits described in clause (i) based on the most recent peer-reviewed and evidence-based data.

(4) ELIGIBILITY AND ENROLLMENT.—

(A) ELIGIBILITY.—An individual who is eligible to purchase coverage from a qualified health plan through an Exchange shall be eligible to enroll in the Plan.

(B) ENROLLMENT PROCESS.—An individual may enroll in the Plan only in such manner and form as may be prescribed by applicable regulations, and only during an enrollment period as prescribed by the Director.

(C) EMPLOYER ENROLLMENT.—An employer shall be eligible to purchase health insurance coverage for their employees and the employees' dependents to the extent provided for all qualified health plans under the Exchanges.

(D) SATISFACTION OF INDIVIDUAL MANDATE REQUIREMENT.—An individual's enrollment with the Plan shall be treated as satisfying any requirement under Federal law for such individual to demonstrate enrollment in health insurance or benefits coverage, including the requirement under section 5000A of the Internal Revenue Code of 1986.

(5) PROVIDERS.—

(A) NETWORK REQUIREMENT.—

(i) MEDICARE.—A participating provider who is voluntarily providing health care services under the Medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall be required to provide services to any individual enrolled in the Plan.

(ii) MEDICAID AND CHIP.—A provider of health care services under the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or the CHIP program established under title XXI of such Act (42 U.S.C. 1397aa et seq.), shall be required to provide services to any individual enrolled in the Plan.

(B) EXCEPTION.—Subparagraph (A) shall not be construed as requiring a provider to accept new patients due to bona fide capacity limitations of the provider.

(C) OPT-OUT PROVISION.—

(i) MEDICARE.—A participating provider as described under subparagraph (A)(i) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a participating provider in the Plan may elect to become a non-participating provider without affecting their status as a participating provider under the Medicare program.

(ii) MEDICAID AND CHIP.—A provider as described under subparagraph (A)(ii) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a provider in the Plan may elect to cease provision of services under the Plan without affecting their status as a provider under the Medicaid program or the CHIP program.

(D) PAYMENT RATES.—

(i) INITIAL PAYMENT RATES.—

(I) IN GENERAL.—During the 2-year period following the establishment of the Plan, providers shall be reimbursed at such payment rates as are applicable under the Medicare program.

(II) ADJUSTMENT.—The Director may reimburse providers at rates lower or higher than applicable under the Medicare program if the Director determines that the adjusted rates are appropriate and ensure that enrollees in the Plan are provided with adequate access to health care services.

(ii) SUBSEQUENT PAYMENT RATES.—Subject to clause (iii), upon the expiration of the 2-year period following the establishment of the Plan, the Director shall develop payment rates for reimbursement of providers in order to maintain an adequate provider network necessary to assure that enrollees in the Plan have adequate access to health care. In determining such payment rates, the Director shall consider—

(I) competitive provider payment rates in both the public and private sectors;

(II) best practices among providers;

(III) integrated models of care delivery (including medical home and chronic care coordination models);

(IV) geographic variation in health care costs;

(V) evidence-based practices;

(VI) quality improvement;

(VII) use of health information technology; and

(VIII) any additional measures, as determined by the Director.

(iii) PAYMENT RATE CONSULTATION.—The Director shall determine payment rates under clause (ii) in consultation with providers participating under the Plan, the Director of the Office of Personnel Management, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment and Access Commission.

(E) ADOPTION OF MEDICARE REFORMS.—The Plan may adopt Medicare system delivery reforms that provide patients with a coordinated system of care and make changes to the provider payment structure.

(6) SUBSIDIES.—The Plan shall be eligible to accept subsidies, including subsidies for the enrollment of individuals under the Plan, in the same manner and to the same extent as other qualified health plans offered through an Exchange (including credits under section 36B of the Internal Revenue Code of 1986).

(7) FINANCING.—

(A) TRANSITIONAL FUNDING.—

(i) IN GENERAL.—In order to provide for adequate funding of the Plan in advance of receipt of payments as described in subparagraph (B), beginning July 1, 2010, there are transferred to the Plan from the general fund of the Treasury such amounts as may be necessary for operation of the Plan until the end of the 3-year period following the establishment of the Plan.

(ii) RETURN OF FUNDS.—Upon the expiration of the 3-year period following the establishment of the Plan, the Director shall enter into a repayment schedule with the Secretary of the Treasury to provide for repayment of funds provided under clause (i). Any expenditures made by the Plan pursuant to a repayment schedule established under this subparagraph shall not constitute administrative expenses as described in subparagraph (B)(ii).

(B) SELF-FINANCING.—

(i) IN GENERAL.—The Plan shall be financially self-sustaining insofar as funds used for operation of the Plan (including benefits, administration, and marketing) shall be derived from—

(I) insurance premium payments and subsidies for individuals enrolled in the Plan; and

(II) assessable payments made pursuant to section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) by employers that fail to offer their full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.

(ii) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided under clause (i) may be used for the annual administrative costs of the Plan.

(C) CONTINGENCY RESERVE.—

(i) IN GENERAL.—The Director shall establish and fund a contingency reserve for the Plan in a form similar to the contingency reserve provided for health benefits plans under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(ii) REVENUE.—Any revenue generated through the contingency reserve established in clause (i) shall be transferred to the Plan for the purpose of reducing enrollee premiums, reducing enrollee cost-sharing, increasing enrollee benefits, or any combination thereof.

(D) GAO FINANCIAL AUDIT AND REPORT.—Beginning not later than October 1, 2011, the Comptroller General shall conduct an annual audit of the financial statements and records of the Plan, in accordance with generally accepted government auditing standards, and submit an annual report on such audit to the Congress.

(E) SUPERMAJORITY REQUIREMENT FOR SUPPLEMENTAL FUNDING.—Upon certification by the Comptroller General that the financial audit described in subparagraph (D) indicates that the Plan is insolvent, supplemental funding may be appropriated for the Plan if such measure receives not less than a three-fifths vote of approval of the total number of Members of the House of Representatives and the Senate.

(8) TRANSPARENCY.—

(A) IN GENERAL.—Beginning with the first year of operation of the Plan through the Exchanges, the Director shall provide standards and undertake activities for promoting transparency in costs, benefits, and other factors for health insurance coverage provided under the Plan.

(B) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—

(i) IN GENERAL.—The Director shall provide for the development of standards for the definitions of terms used in health insurance

coverage under the Plan, including insurance-related terms (including the insurance-related terms described in clause (ii)) and medical terms (including the medical terms described in clause (iii)).

(ii) INSURANCE-RELATED TERMS.—The insurance-related terms described in this clause are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Director determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(iii) MEDICAL TERMS.—The medical terms described in this clause are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Director determines are important to define so that consumers may compare the medical benefits offered by health insurance plans and understand the extent of those medical benefits (or exceptions to those benefits).

(C) DISCLOSURE.—

(i) IN GENERAL.—In carrying out this paragraph, the Director shall disclose to Plan enrollees, potential enrollees, in-network health care providers, and others (through a publically available Internet website and other appropriate means) relevant information regarding each policy of health insurance coverage marketed or in force (in such standardized manner as determined by the Director), including—

(I) full policy contract language; and

(II) a summary of the information described in subparagraph (D).

(ii) PERSONALIZED STATEMENT.—The Director shall disclose to enrollees (in such standardized manner as determined by the Director) an annual personalized statement that summarizes use of health care services and payment of claims with respect to an enrollee (and covered dependents) under health insurance coverage provided through the Plan in the preceding year.

(D) REQUIRED INFORMATION.—The information described in this subparagraph includes, but is not limited to, the following:

(i) Data on the price of each new policy of health insurance coverage and renewal rating practices.

(ii) Claims payment policies and practices, including how many and how quickly claims were paid.

(iii) Provider fee schedules and usual, customary, and reasonable fees (for both in-network and out-of-network providers).

(iv) Provider participation and provider directories.

(v) Loss ratios, including detailed information about amount and type of non-claims expenses.

(vi) Covered benefits, cost-sharing, and amount of payment provided toward each type of service identified as a covered benefit, including preventive care services recommended by the United States Preventive Services Task Force.

(vii) Civil or criminal actions successfully concluded against the Plan by any governmental entity.

(viii) Benefit exclusions and limits.

(E) DEVELOPMENT OF PATIENT CLAIMS SCENARIOS.—

(i) IN GENERAL.—In order to improve the ability of individuals and employers to compare the coverage and relative value provided under the Plan, the Director shall develop and make publically available a series of patient claims scenarios under which benefits (including out-of-pocket costs) under the Plan are simulated for certain common or expensive conditions or courses of treatment (including maternity care, breast cancer, heart disease, diabetes management, and well-child visits).

(ii) CONSULTATION.—The Director shall develop the patient claims scenarios described in clause (i)—

(I) in consultation with the Secretary of Health and Human Services, the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, health professional societies, patient advocates, and other entities as deemed necessary by the Director; and

(II) based upon recognized clinical practice guidelines.

(F) MANNER OF DISCLOSURE.—The Director shall disclose the information under this paragraph—

(i) with all marketing materials;

(ii) on the website for the Plan; and

(iii) at other times upon request.

(d) CONFORMING AMENDMENTS.—

(1) COMMUNITY HEALTH INSURANCE OPTION.—

(A) IN GENERAL.—Title I of this Act is amended by striking ''community health insurance option'' each place it appears and inserting ''Consumer Choice Health Plan''.

(B) ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.—Section 9010(c)(2)(B) is amended by striking ''community health insurance option'' and inserting ''Consumer Choice Health Plan''.

(2) SPECIAL RULES.—Section 1303(a)(1)(C) is amended by—

(A) in clause (i)(III), striking ''section 1323(e)(1)(C) or''; and

(B) in clause (ii), striking ''section 1323(b)(3)(A)'' and inserting ''section 1323(c)(3)(A)''.

SEC. 1323A. ESTABLISHMENT OF AMERICA'S HEALTH INSURANCE TRUST.

(a) ESTABLISHMENT.—As of the date of enactment of this Act, there is authorized to be established a non-profit corporation that shall be known as the ''America's Health Insurance Trust'' (referred to in this section and section 1323B as the ''Trust''), which is neither an agency nor establishment of the United States Government.

(b) LOCATION; SERVICE OF PROCESS.—The Trust shall maintain its principal office within the District of Columbia and have a designated agent in the District of Columbia to receive service of process for the Trust. Notice to or service on the agent shall be deemed as notice to or service on the corporation.

(c) APPLICATION OF PROVISIONS.—The Trust shall be subject to the provisions of this section and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

(d) TAX EXEMPT STATUS.—The Trust shall be treated as a nonprofit organization described under section 170(c)(2)(B) and section 501(c)(3) of the Internal Revenue Code of 1986 that is exempt from taxation under section 501(a) of the Internal Revenue Code of 1986.

(e) BOARD OF DIRECTORS.—

(1) IN GENERAL.—The Board of Directors of the Trust (referred to in this section as the ''Board'') shall consist of 19 voting members appointed by the Comptroller General.

(2) TERMS.—

(A) IN GENERAL.—Subject to subparagraph (C), each member of the Board shall serve for a term of 6 years.

(B) LIMITATION.—No individual shall be appointed to the Board for more than 2 consecutive terms.

(C) INITIAL MEMBERS.—The initial members of the Board shall be appointed by the Comptroller General not later than October 1, 2010, and shall serve terms as follows:

(i) 8 members shall be appointed for a term of 5 years.

(ii) 8 members shall be appointed for a term of 3 years.

(iii) 3 members shall be appointed for a term of 1 year.

(D) EXPIRATION OF TERM.—Any member of the Board whose term has expired may serve until such member's successor has taken office, or until the end of the calendar year in which such member's term has expired, whichever is earlier.

(E) VACANCIES.—

(i) IN GENERAL.—Any member appointed to fill a vacancy prior to the expiration of the term for which such member's predecessor was appointed shall be appointed for the remainder of such term.

(ii) VACANCIES NOT TO AFFECT POWER OF BOARD.—A vacancy on the Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(3) CHAIRPERSON AND VICE-CHAIRPERSON.—

(A) IN GENERAL.—The Comptroller General shall designate a Chairperson and Vice-Chairperson of the Board from among the members of the Board.

(B) TERM.—The members designated as Chairperson and Vice-Chairperson shall serve for a period of 3 years.

(4) CONFLICTS OF INTEREST.—An individual may not serve on the Board if such individual (or an immediate family member of such individual) is employed by or has a financial interest in—

(A) an organization that provides a health insurance plan;

(B) a pharmaceutical manufacturer; or

(C) any subsidiary entities of an organization described in subparagraphs (A) or (B).

(5) COMPOSITION OF THE BOARD.—

(A) POLITICAL PARTIES.—Not more than 10 members of the Board may be affiliated with the same political party.

(B) DIVERSITY.—In appointing members under this paragraph, the Comptroller General shall ensure that such members provide appropriately diverse representation with respect to race, ethnicity, age, gender, and geography.

(C) CONSUMER REPRESENTATION.—10 members of the Board shall be independent and non-conflicted individuals representing the interests of health care consumers. Each member selected under this subparagraph shall represent 1 of the 10 Department of Health and Human Services regions in the United States.

(D) REMAINING REPRESENTATION.—

(i) IN GENERAL.—9 members of the Board shall be selected based on relevant experience, including expertise in—

(I) community affairs;

(II) Federal, State, and local government;

(III) health professions and administration;

(IV) business, finance, and accounting;

(V) legal affairs;

(VI) insurance;

(VII) trade unions;

(VIII) social services; and

(IX) any additional areas as determined by the Comptroller General.

(ii) INCOME FROM HEALTH CARE INDUSTRY.—Not more than 4 of the members selected under this subparagraph shall earn more than 10 percent of their income from the health care industry.

(6) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings of the Board on matters not related to personnel shall be open to the public and advertised through public notice at least 7 days prior to the meeting.

(7) QUORUM.—A majority of the members of the Board shall constitute a quorum for purposes of conducting the duties of the Trust,

but a lesser number of members may meet and hold hearings.

(8) EXECUTIVE DIRECTOR AND STAFF; PERFORMANCE OF DUTIES.—The Board may—

(A) employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Trust;

(B) seek such assistance and support as may be required in the performance of the duties of the Trust from appropriate departments and agencies of the Federal Government;

(C) enter into contracts or other arrangements and make such payments as may be necessary for performance of the duties of the Trust;

(D) provide travel, subsistence, and per diem compensation for individuals performing the duties of the Trust, including members of the Advisory Council (as described in subsection (f)); and

(E) prescribe such rules, regulations, and bylaws as the Board determines necessary with respect to the internal organization and operation of the Trust.

(9) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE BOARD.—Section 207(c) of title 18, United States Code, as amended by section 3403(a)(2), is amended by inserting at the end the following:

''(4) MEMBERS OF THE BOARD OF DIRECTORS OF THE AMERICA'S HEALTH INSURANCE TRUST.—Paragraph (1) shall apply to a member of the Board of Directors of the America's Health Insurance Trust who was appointed to the Board as of the day before the date of enactment of the Patient Protection and Affordable Care Act.''.

(f) ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—The Board shall establish an advisory council that shall be comprised of the insurance commissioners of each State (including the District of Columbia) to advise the Board on the development and impact of measures to improve the transparency and accountability of qualified health plans provided through the Exchanges established under this title.

(2) MEETINGS.—The advisory council shall meet not less than twice a year and at the request of the Board.

(g) FINANCIAL OVERSIGHT.—

(1) CONTRACT FOR AUDITS.—The Trust shall provide for financial audits of the Trust on an annual basis by a private entity with expertise in conducting financial audits.

(2) REVIEW AND REPORT ON AUDITS.—The Comptroller General shall—

(A) review and evaluate the results of the audits conducted pursuant to paragraph (1); and

(B) submit a report to Congress containing the results and review of such audits, including an analysis of the adequacy and use of the funding for the Trust and its activities.

(h) RULES ON GIFTS AND OUTSIDE CONTRIBUTIONS.—

(1) GIFTS.—The Trust (including the Board and any staff acting on behalf of the Trust) shall not accept gifts, bequeaths, or donations of services or property.

(2) PROHIBITION ON OUTSIDE FUNDING OR CONTRIBUTIONS.—The Trust shall not—

(A) establish a corporation other than as provided under this section; or

(B) accept any funds or contributions other than as provided under this section.

(i) AMERICA'S HEALTH INSURANCE TRUST FUND.—

(1) IN GENERAL.—There is established in the Treasury a trust fund to be known as the ''America's Health Insurance Trust Fund'' (referred to in this section as the ''Trust Fund''), consisting of such amounts as may be credited to the Trust Fund as provided under this subsection.

(2) TRANSFER.—The Secretary of the Treasury shall transfer to the Trust Fund out of the general fund of the Treasury amounts determined by the Secretary to be equivalent to the amounts received into such general fund that are attributable to the fees collected under sections 4385 and 4386 of the Internal Revenue Code of 1986 (relating to fees on health insurance policies and self-insured health plans).

(3) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter C—Additional Fees on Insured and Self-Insured Health Plans

''Sec. 4385. Health insurance.
''Sec. 4386. Self-insured health plans.
''Sec. 4387. Definitions and special rules.

''SEC. 4385. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—In the case of any specified health insurance policy issued after October 1, 2009, there is hereby imposed a fee equal to—

''(1) for policies issued during fiscal years 2010 through 2013, 50 cents multiplied by the average number of lives covered under the policy; and

''(2) for policies issued after September 30, 2013, $1 multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy shall be equal to the sum of such dollar amount for policies issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for policies issued in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

''SEC. 4386. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan issued after October 1, 2009, there is hereby imposed a fee equal to—

''(1) for plans issued during fiscal years 2010 through 2013, 50 cents multiplied by the average number of lives covered under the plan; and

''(2) for plans issued after September 30, 2013, $1 multiplied by the average number of lives covered under the plans.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan shall be equal to the sum of such dollar amount for plans issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for plans issued in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health

Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to plans issued after September 30, 2019.

''SEC. 4387. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4385(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4385 or section 4386 on any covered policy or plan under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code,

''(D) the Consumer Choice Health Plan established under section 1323 of the Patient Protection and Affordable Care Act,

''(E) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(F) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''SUBCHAPTER C. ADDITIONAL FEES ON INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

SEC. 1323B. DUTIES OF AMERICA'S HEALTH INSURANCE TRUST.

(a) INSURANCE PLAN RANKINGS AND WEBSITE.—

(1) WEB-BASED MATERIALS.—The Trust shall establish and maintain a website that provides informational materials regarding the qualified health plans provided through the Exchanges established under this title, including appropriate links for all available State insurance commissioner websites.

(2) PLAN RANKINGS.—The Trust shall develop and publish annual rankings of the qualified health plans provided through the Exchanges, based on the assignment of a letter grade between ''grade A'' (highest) and ''grade F'' (lowest). The Trust shall provide for a comparative evaluation of each plan based upon—

(A) administrative expenditures;

(B) affordability of coverage;

(C) adequacy of coverage;

(D) timeliness and adequacy of consumer claims processing;

(E) available consumer complaint systems;

(F) grievance and appeals processes;

(G) transparency;

(H) consumer satisfaction; and

(I) any additional measures as determined by the Board.

(3) INFORMATION AVAILABLE ON WEBSITE BY ZIP CODE.—The annual rankings of the qualified health plans (as described in paragraph (2)) shall be available on the website for the Trust (as described in paragraph (1)), and websites for the Exchanges, in a manner that is searchable and sortable by zip code.

(4) CONSUMER FEEDBACK.—

(A) CONSUMER COMPLAINTS.—The Trust shall develop written and web-based methods for individuals to provide recommendations and complaints regarding the qualified health plans provided through the Exchanges.

(B) CONSUMER SURVEYS.—The Trust shall obtain meaningful consumer input, including consumer surveys, that measure the extent to which an individual receives the services and supports described in the individual's health insurance plan and the individual's satisfaction with such services and supports.

(b) DATA SHARING.—

(1) IN GENERAL.—An organization that provides a qualified health plan through an Exchange shall provide the Trust with all information and data that is necessary for improving transparency, monitoring, and oversight of such plans.

(2) ANNUAL DISCLOSURE.—Beginning with the first full year for which Exchanges are required to be operational under this title, an organization that provides a qualified health plan through an Exchange shall annually provide the Trust with appropriate information regarding the following:

(A) Name of the plan.

(B) Levels of available plan benefits.

(C) Description of plan benefits.

(D) Number of enrollees under the plan.

(E) Demographic profile of enrollees under the plan.

(F) Number of claims paid to enrollees.

(G) Number of enrollees that terminated their coverage under the plan.

(H) Total operating cost for the plan (including administrative costs).

(I) Patterns of utilization of the plan's services.

(J) Availability, accessibility, and acceptability of the plan's services.

(K) Such information as the Trust may require demonstrating that the organization has a fiscally sound operation.

(L) Any additional information as determined by the Trust.

(3) FORM AND MANNER OF INFORMATION.—Information to be provided to the Trust under paragraphs (1) and (2) shall be provided—

(A) in such form and manner as specified by the Trust; and

(B) within 30 days of the date of receipt of the request for such information, or within such extended period as the Trust deems appropriate.

(4) INFORMATION FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(A) IN GENERAL.—Any information regarding the qualified health plans that are offered through the Exchanges that has been provided to the Secretary of Health and Human Services shall also be made available (as deemed appropriate by the Secretary) to the Trust for the purpose of improving transparency, monitoring, and oversight of such plans. Such information may include, but is not limited to, the following:

(i) Underwriting guidelines to ensure compliance with applicable Federal health insurance requirements.

(ii) Rating practices to ensure compliance with applicable Federal health insurance requirements.

(iii) Enrollment and disenrollment data, including information the Secretary may need to detect patterns of discrimination against individuals based on health status or other characteristics, to ensure compliance with applicable Federal health insurance requirements (including non-discrimination in group coverage, guaranteed issue, and guaranteed renewability requirements applicable in all markets).

(iv) Post-claims underwriting and rescission practices to ensure compliance with applicable Federal health insurance requirements relating to guaranteed renewability.

(v) Marketing materials and agent guidelines to ensure compliance with applicable Federal health insurance requirements.

(vi) Data on the imposition of pre-existing condition exclusion periods and claims subjected to such exclusion periods.

(vii) Information on issuance of certificates of creditable coverage.

(viii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(ix) The application to issuers of penalties for violation of applicable Federal health insurance requirements (including failure to produce requested information).

(x) Such other information as the Trust may determine to be necessary to verify compliance with the requirements of this section.

(B) REQUIRED DISCLOSURE.—The Secretary of Health and Human Services shall provide the Trust with all consumer claims data or information that has been provided to the Secretary by any qualified health plan that is offered through an Exchange.

(C) PERIOD FOR PROVIDING INFORMATION.—Information to be provided to the Trust under this paragraph shall be provided by the Secretary within 30 days of the date of receipt of the request for such information, or within such extended period as the Secretary and the Trust mutually deem appropriate.

(5) NON-DISCLOSURE OF HEALTH INSURANCE DATA.—The Trust shall prevent disclosure of any data or information provided under this paragraph that the Trust determines is proprietary or qualifies as a trade secret subject to withholding from public dissemination. Any data or information provided under this paragraph shall not be subject to disclosure under section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act).

SA 2950. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 34, between lines 4 and 5, insert the following:

"SEC. 2720. LIMITATION ON ANNUAL GROWTH IN HEALTH INSURANCE PREMIUMS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not increase the health insurance premium rates for such plan or coverage in any year by a percentage that is greater than the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers for year involved.

''(b) EFFECT.—If a plan or an issuer increases the health insurance premium rate by a percentage greater than the percentage described in subsection (a), that plan or issuer shall refund the excess premium dollars back to the enrollee or to the Federal treasury, in amounts equal to the respective premium contributions of the enrollee and the Federal Government, taking into account premium subsidies provided to individuals or families for coverage purchased in an Exchange.''.

SA 2951. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 112, between lines 8 and 9, insert the following:

(5) MAXIMUM TOTAL OUT-OF-POCKET EXPENSES.—

(A) IN GENERAL.—Notwithstanding any other provision of this Act (or any amendments made by this Act), in no case may out-of-pocket expenses incurred under a health plan with respect to self-only coverage or coverage other than self-only exceed the following limits for any plan year beginning in or after 2014:

(i) 7.5 percent of annual household income for an individual with household income under 200 percent of the poverty line for the size of the family involved.

(ii) 10 percent of annual household income for an individual with household income between 200 and 400 percent of the poverty line for the size of the family involved.

(iii) 12 percent of annual household income for an individual with household income above 400 percent of the poverty line for the size of the family involved.

(B) OUT-OF-POCKET EXPENSES.—In this paragraph, the term ''out-of-pocket expenses'' includes deductibles, coinsurance, copayments, premiums, balance billing amounts for non-network providers, and similar charges.

SA 2952. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1925, between lines 14 and 15, insert the following:

Subtitle C—Provisions Relating to Authorized Generic Drugs

SEC. 7201. PROHIBITION OF AUTHORIZED GENERICS.

(a) IN GENERAL.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by adding at the end the following:

''(w) PROHIBITION OF AUTHORIZED GENERIC DRUGS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act, no holder of a new drug application approved under subsection (c) shall manufacture, market, sell, or distribute an authorized generic drug, direct or indirectly, or authorize any other person to manufacture, market, sell, or distribute an authorized generic drug.

''(2) AUTHORIZED GENERIC DRUG.—For purposes of this subsection, the term 'authorized generic drug'—

''(A) means any version of a listed drug (as such term is used in subsection (j)) that the holder of the new drug application approved under subsection (c) for that listed drug seeks to commence marketing, selling, or distributing, directly or indirectly, after receipt of a notice sent pursuant to subsection (j)(2)(B) with respect to that listed drug; and

''(B) does not include any drug to be marketed, sold, or distributed—

''(i) by an entity eligible for exclusivity with respect to such drug under subsection (j)(5)(B)(iv); or

''(ii) after expiration or forfeiture of any exclusivity with respect to such drug under such subsection (j)(5)(B)(iv).''.

(b) CONFORMING AMENDMENT.—Section 505(t)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(t)(3)) is amended by striking ''In this section'' and inserting ''In this subsection''.

ORDERS FOR MONDAY, DECEMBER 7, 2009

Mr. BEGICH. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Monday, December 7; 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; that following leader remarks, the first 2 hours be equally divided and controlled between the two leaders or their designees, with Senators permitted to speak therein for up to 10 minutes each, with the Republicans controlling the first 30 minutes, and the majority controlling the next 30 minutes, and with no amendments or motions in order during the controlled time.

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

PROGRAM

Mr. BEGICH. Mr. President, rollcall votes in relation to the amendments to the health care reform bill are expected to occur after 3:15 p.m. tomorrow.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. BEGICH. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 5:24 p.m., adjourned until Monday, December 7, 2009, at 10 a.m.