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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable PAUL G. KIRK, Jr., a Senator from the Commonwealth of Massachusetts.

PRAYER

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

Let us pray.

God of justice, bring wholeness to our world. Keep fear, ignorance, and pride from limiting Your work in our Nation.

Give the Members of this body the insight to understand the actions they should take during these challenging times. Quicken their hearts and purify their minds. Broaden their concerns and strengthen their commitments. Lord, lead them through this season of challenge to a deeper experience with You, enabling them to feel You in their midst, as they grapple with the problems of our time.

We pray in Your Holy Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable PAUL G. KIRK, Jr., 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 9, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable PAUL G. KIRK, Jr., a Senator from the Commonwealth of Massachusetts, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

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

NOTICE

If the 111th Congress, 1st Session, adjourns sine die on or before December 23, 2009, a final issue of the *Congressional Record* for the 111th Congress, 1st Session, will be published on Thursday, December 31, 2009, to permit Members to insert statements.

All material for insertion must be signed by the Member and delivered to the respective offices of the Official Reporters of Debates (Room HT–59 or S–123 of the Capitol), Monday through Friday, between the hours of 10:00 a.m. and 3:00 p.m. through Wednesday, December 30. The final issue will be dated Thursday, December 31, 2009, and will be delivered on Monday, January 4, 2010.

None of the material printed in the final issue of the *Congressional Record* may contain subject matter, or relate to any event, that occurred after the sine die date.

Senators' statements should also be formatted according to the instructions at http://webster/secretary/cong__record.pdf, and submitted electronically, either on a disk to accompany the signed statement, or by e-mail to the Official Reporters of Debates at "Record@Sec.Senate.gov".

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

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By order of the Joint Committee on Printing.

CHARLES E. SCHUMER, *Chairman.*

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

RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Mr. President, following leader marks, the Senate will resume consideration of the health care reform legislation. Following remarks by the chairman and ranking member of the Finance Committee or their designees, the next 2 hours will be equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each. The Republicans will control the first 30 minutes and the majority will control the second 30 minutes. The remaining time will be equally divided and used in alternating fashion. No amendments are in order during the controlled time. Rollcall votes could occur this afternoon, but at this stage we have no knowledge that we have worked anything out and don't know if we will. We will do our best to give Members as much notice as possible.

HEALTH CARE REFORM

Mr. REID. Mr. President, much of this momentous health care debate revolves around numbers, as it should. We read them in reports, see them in charts, and hear about them in speeches. The state of health care in this country is in such a severe crisis that these numbers are often quite overwhelming. Today, I want to talk about 1 number—31. It has a special significance, especially today, along the course of this long, historic pursuit to make it possible for every American to have health insurance and good health.

First, let's discuss the future.

The number 31 is a powerful reminder of both the great opportunity before us and the great cost of inaction, a tangible illustration of what we stand to gain and what we stand to lose. When we pass this bill, 31 million Americans who today have no health insurance will have health insurance at long last. That means they no longer will have to put off the surgery they need and will be able to finally use prescriptions as prescribed—not half a pill every day, a whole pill every day. It means 31 million Americans will have a decent shot at a healthy life.

If we don't act, if we let misinformation confuse us or let distractions divert us or refuse to answer the American people's call to action, many more will suffer. In Nevada, like every other State, health insurance costs continue to climb. If we don't act, in just 6 years, the typical Nevada family will spend more than 31 percent of their income on health care premiums. Almost a third of every Nevadan's paycheck will go right to his or her insurance company. That number is even higher on average throughout the country but only if we do nothing.

Second, let's talk for just a little bit about today, the present.

Right now, every 31 minutes insurance companies terminate insurance for 300 Americans. Sometimes it is because you lost your job, because you lost your health care when you lost your job. Sometimes it is because you change your job but your health care company doesn't come along with your job change. And sometimes, at the very time you need it the most, the insurance company says: Sorry. We are not going to continue the insurance we have given you before. Because they want to make more money, a greedy health insurance company looks at your medical history and says: I am sorry, but we are going to take it away from you. You have no recourse. Maybe you have had high cholesterol your whole life or maybe acne as a child or you had a C-section as an adult. Health insurance companies have used all these reasons to drop someone's coverage. Maybe you had minor surgery 10 years ago or your mother had breast cancer or your father had heart disease. That is all it takes. We all know that, much like our Republican colleagues, insurance companies will use any excuse in the book to say no.

But that statistic, that every 31 minutes in America more than 300 people lose their health insurance coverage, what does that really mean? Imagine if the Senate gallery—600 people can be seated in our galleries—imagine if every single one of these seats was filled by a good American citizen who wanted to look over the Senate and they all had health care when they came in here. Imagine that each of them came this morning to watch their government work, to observe the proceedings here on the floor for an hour or so. Then each of them went on their way when that hour came to a close, but on their way out the door they were told that no longer would they have health care. That is what is happening right now in America, the wealthiest and greatest country in the world. Every 31 minutes, 300 more people lose their health coverage.

Third and finally, let's talk about the past. Let's put the historical moment upon us in the context of history.

It was 31 years ago this day that Senator Ted Kennedy gave one of the most profound and stirring speeches both of his remarkable life and in the history of the Senate and certainly in the history of our Nation's long health care debate. In that talk, he made an observation that rings just as true today as it did more than three decades ago. He said:

> One of the most shameful things about modern America is that in our unbelievably rich land, the quality of the health care available to many of our people is unbelievably poor and the cost is unbelievably high.

Senator Kennedy observed how out of control costs were back in 1978 and warned how quickly they would rise if we did not act.

Well, we didn't act. In the past 31 years, health care costs have skyrocketed, and that is a gross understatement. The number of uninsured Americans has done the same. We have 50 million now uninsured and more bankruptcies than ever. Three out of five are because of medical expenses. Other countries have no bankruptcies because of medical expenses. Germany, France, Great Britain, Japan—they don't have bankruptcies because of health expenses. The cost of prescription drugs has doubled in just the past decade, and far fewer small businesses can afford to cover their workers. One more thing has happened: The resistance of the health insurance industry and congressional Republicans to change the American people's demand has only become more tone deaf and more intense.

If we don't act at this time, those terrible trends will only continue. I can hear Senator Kennedy now. I wasn't here 31 years ago, but I can hear him because I listened to him very closely for more than 31 years. Costs will continue to go up without end. More Americans who have health insurance today will lose it. More patients will die of diseases we know how to treat. As the crisis spirals, insurance company executives will laugh all the way to the bank. One company made $1 billion last year; the chief executive took home $100 million. How is that?

Much of the health care debate revolves around numbers, but at its heart, it is really about people. On December 9, 1978, 31 years ago, Senator Ted Kennedy asked us to recognize that health care is ''a basic right for all, not just an expensive luxury for the few.'' A generation later, good health is still a luxury in this country. We are working day and night to see if we can help the generation that is here now and generations to come. If we don't, they will have the same memories 31 years from now as Senator Kennedy prophesied 31 years ago.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE: IMPACT ON SMALL BUSINESS

Mr. MCCONNELL. Mr. President, the American people have now seen what Democrats in Congress plan to do with seniors' health care. They have looked on in total disbelief as the majority voted again and again to slash Medicare by nearly $½ trillion.

Incredibly, these cuts represent just part of the pain caused by this bill. In addition to punishing seniors, it would punish businesses. At a time when 1 out of 10 working Americans is looking for a job, this bill would hit employers

with job-killing new taxes and mandates, and it wouldn't do anything to lower long-term health care costs. This is the very last thing business owners expected from this bill. It is the last thing America needs in the midst of a recession. And it is just one of the reasons more and more business groups are stepping forward and speaking out against this job-killing bill.

Yesterday, I mentioned a letter signed by 10 major trade groups pleading with us not to approve this bill because of the effect it would have on business. Later in the day, the National Federation of Independent Business, one of the leaders in the small business community, released a letter explaining why they opposed the bill. They said any health care reform faces two tests for small businesses: Does it lower insurance costs, and will it increase the overall cost of doing business. According to them, the Senate bill fails both of these tests and therefore fails small business. They have seen the CBO conclude that this bill would lead to higher premiums. They have seen the billions of new taxes that would fall unfairly on small businesses. And they have seen the mandates and the fines that would kill jobs. They have concluded that this bill would actually be worse for small business than the current situation.

It is abundantly clear that the more Americans learn about this bill, the more they oppose it. Now we know the same goes for business. Businesses that can't insure workers face stiff fines resulting in lost wages and jobs, according to the independent Congressional Budget Office.

What is more, studies suggest that this so-called employer mandate would have a disproportionate impact on low-income, entry-level workers. At a time of 10 percent unemployment, we should be doing everything we can to create jobs. This bill would only lead to more lost jobs.

Medicare cuts are bad enough, but this bill doesn't just hurt seniors, it hurts the economy as well. That is why Americans overwhelmingly oppose it.

Speaking of how people feel about this bill, we see signs of opposition everywhere. Public opinion is overwhelming. In all the polls across the country, the American people are saying: Don't pass this bill.

Last month's gubernatorial elections in New Jersey and Virginia were a stinging rebuke to the Democratic approach of more spending, more debt, higher taxes, and endless bureaucracy.

There is a new development. Just yesterday—just yesterday in my home State—there was a special election for the State senate. Why would that be worthy of commentary on the Senate floor? Let me describe the situation. It is a 3-to-1 Democratic district. Because of State issues, the Democratic State administration was intensely interested in winning that seat. They spent $1 million cumulatively—the candidate, the Democratic State party, and an outside interest group—in support of the Democrat—$1 million on one side of a State senate race in a rural area of my State.

On the other side was a Republican candidate, who was outspent 5 to 1—outspent 5 to 1 in a 3-to-1 Democratic district. The Republican candidate for the State senate won by 12 points. How did that happen? He had one message—one message: oppose the Reid bill, oppose what PELOSI is doing, oppose what the Democrats in Washington are doing.

In other words, the candidate who was outspent 5 to 1 in a district where he was outregistered 3 to 1 made the sole issue in the State senate race what is happening here in Washington on this bill that is on this floor.

That ought to tell you on the heels of the Virginia and New Jersey elections what is happening in this country. People have seen enough and heard enough, and they want it to stop.

The message is simple. This health care bill is a losing formula all around. That is the message Americans are sending loudly and clearly. The signs are everywhere. We saw it yesterday in my home State. It is time to stop this bill and start over.

Mr. President, I yield the floor.

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 assistant legislative clerk read as follows:

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

Pending:

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

Dorgan modified amendment No. 2793 (to amendment No. 2786), to provide for the importation of prescription drugs.

Crapo motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, following any remarks of the chairman and ranking member of the Finance Committee or their designees, for up to 10 minutes each, the next 2 hours will be for debate only, with the time equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each, with the Republicans controlling the first 30 minutes, and the majority controlling the second 30 minutes, and with the remaining time equally divided and used in an alternating fashion.

The Senator from Montana.

Mr. BAUCUS. Mr. President, for the benefit of all Senators, let me lay out today's program.

It has been nearly 3 weeks since the majority leader moved to proceed to the health care reform bill. This is the 10th day of debate on the bill. The Senate has considered 18 amendments or motions. We have conducted 14 rollcall votes.

Today the Senate will debate the amendment by the Senator from North Dakota, Mr. DORGAN, on prescription drug reimportation. At the same time, we will debate the motion by the Senator from Idaho, Mr. CRAPO, on taxes.

Under the previous order, the time until 12:30 p.m. today will be for debate only, with the time equally divided and controlled between the two leaders or their designees. Following the remarks of the ranking member of the Finance Committee or his designee, the Republicans will control the first 30 minutes and the majority will control the second 30 minutes, with the remaining time equally divided and used in an alternating manner.

We are hopeful the Senate will be able to conduct votes on or in relation to a second-degree amendment to the Dorgan amendment, the Dorgan amendment itself, a side by side to the Crapo motion, and the Crapo motion itself. Thereafter, we expect to turn to another Democratic first-degree amendment and another Republican first-degree amendment. We are working on lining those up.

Over the course of the debate, there has been too much misinformation about what health care reform is and what it will do. I wish to set the record straight.

The goal of health care reform is to lower costs and provide quality, affordable coverage to American families, businesses, and workers. According to the nonpartisan Congressional Budget Office, our bill, the Patient Protection and Affordable Care Act, is a success.

According to the CBO, this bill provides health insurance coverage to 31 million more Americans. That is a big success. It lowers health insurance premiums. Despite what some have said, what some have claimed about premiums rising, that is not true. CBO says this legislation lowers health insurance premiums but for 7 percent, and that 7 percent gets much higher quality health care insurance than otherwise they would get. CBO also says this legislation reduces the Federal deficit by $130 billion over the first 10 years—it reduces the Federal deficit by $130 billion over the first 10 years.

In addition, as the President promised, this bill does not raise taxes on the middle class. In fact, this bill is a net tax cut. Over the next 10 years, this bill will provide a total of $441 billion in tax credits to help American families buy quality, affordable health care coverage they can count on. That is a tax cut, a total of $441 billion in tax cuts. The chart behind me indicates

that. Over the next 10 years, this bill will provide a total of, as I said, $441 billion in tax cuts.

The bill provides a net tax cut of $40 billion in the year 2017. You can see that basically on the chart: $40 billion of tax cuts in 2017. That is $440 for every taxpayer affected. These are individual tax cuts. Let me make that clear. American individuals will get tax cuts under this legislation in these amounts.

That same year—2017—low- and middle-income taxpayers who earn between $20,000 and $30,000 a year will see an average Federal tax decrease of nearly 37 percent. That is CBO. Do not take my word for it. That is CBO and the Joint Committee on Taxation—an independent organization. The average taxpayer making less than $75,000 a year will receive a tax credit of more than $1,300, and that tax credit grows to more than $1,500 in 2019. Those are tax cuts. It is very important we all remember this bill is a net tax cut of this amount for American taxpayers. That is individual tax cuts.

I have heard arguments that the responsibility to have health insurance amounts to a tax on the middle class. This is simply not true. In fact, this policy works to repeal the hidden tax of more than $1,000 in extra insurance premiums that American families with health insurance pay each year in order to cover the cost of caring for those without health insurance. It is a tax for uncompensated care. That is $1,000 per American family, on average, that they have to pay under the current system. This bill would virtually eliminate that.

Additionally, this bill provides Americans with the tools they need to meet that responsibility by ensuring that all Americans have access to quality, affordable health insurance.

The bill eliminates barriers that prevent Americans from getting insurance coverage, such as discrimination based on preexisting conditions. This bill eliminates that. We—all of us—either directly or through a family member or through a friend, have heard these horror stories of insurance companies denying coverage because of a preexisting condition. This legislation stops this. And this legislation makes quality insurance affordable to every American through tax cuts and help with copays and other out-of-pocket costs.

If for some reason an individual still cannot afford to buy the health insurance coverage available to them, they are exempt from paying the penalty. Clearly, this penalty is not a tax. So if you cannot afford it, you do not have to pay—no penalty.

I have also heard arguments that the excise tax on private insurance companies offering costly and excessive insurance plans will raise taxes on individuals. This claim is equally untrue. The Congressional Budget Office reaches the conclusion that is not true. In fact, the Congressional Budget Office reaches the conclusion it will lower premiums. I think the amount is 7 to 12 percent, if I remember correctly—the amount stated in their letter to us in the Congress.

This policy, therefore, is not a tax on individuals. Rather, it is a tax on private insurance companies, and not passed on in the nature of higher premiums, according to CBO—in fact, lower premiums according to CBO.

This legislation is designed to encourage private insurance companies to offer, and employers to choose, health insurance plans with lower premiums that are below the taxable threshold. The Congressional Budget Office noted how effective this policy is in a report when it said:

> . . . most people would avoid the cost of the excise tax by enrolling in plans that had lower premiums.

As a result, CBO says premiums will decrease and wages will increase as employers offer more money in workers' pockets instead of inflated health benefits. In fact, the bulk of the revenue raised by this provision—more than 83 percent—comes not from the tax itself but from increased wages, increased wages on account of this provision. MIT economist Jonathan Gruber estimates this provision will cause workers' wages to rise by $55 in 2019. That is $700 in additional income for every household with health insurance.

The truth is, this bill is fully paid for—fully paid for; CBO says so—and it is paid for in a fiscally responsible way. It reduces the Federal deficit. It lowers the growth of health care costs. It provides quality, affordable health insurance to millions more Americans. And it is a net tax cut—net tax cut—for American families, businesses, and workers, which in these tough economic times means more than ever.

The ACTING PRESIDENT pro tempore. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I stand confused from the statement of the chairman of the Finance Committee because we have all the reports that the bill he is talking about is not the bill we are going to be voting on because we are totally changing what we are doing. What is out there now is that we are going to expand Medicare to those down to 55 years of age, and we are going to expand Medicaid up to those of 150 percent of poverty. We are going to add billions of dollars of mandates, even at 90 percent copaid by the Federal Government, to the States over the next 10 years. We have a Medicare Program that you have taken $465 billion out of, and you are going to add 34 million new people to under the new plan—the new plan we are talking about. You are talking about the plan we used to have.

It is interesting, though, as you make those points, when you say it is net tax cut. Three-quarters of the net tax cut goes to people in this country who pay no taxes in the first place. The chairman cannot deny that. The fact is, according to the Joint Tax Committee—the chairman conveniently does not look at the other body that gives us information on taxes. According to the Joint Tax Committee, $288 billion of the $394 billion will be refundable. That is a refundable tax credit to people who are paying no taxes now.

Mr. BAUCUS. Mr. President, might I ask the Senator, it is a tax cut, whether or not it is refundable. And even if it is refundable, it is extra dollars in people's pockets.

Mr. COBURN. The fact is, it is taxes to the average American family—40 million of them. According to the Joint Tax Committee, taxes will rise on those who are making under $200,000 a year. The Joint Tax Committee said that.

The point is, what you are talking about does not have any application because we do not have ''the bill,'' again, because we have a new ''the bill'' on the floor, which is going to take a bankrupt program that our children today are responsible for—if you are born today, based on the unfunded liabilities of Medicare, you are responsible for $350,000, if you are a new child born today, for what we have not paid for in Medicare. And now we have the new plan that is going to come out. We have cut $465 billion out of Medicare, or moved it out of Medicare, to create a new program. And we are going to add 34 million new Americans to it, in a plan that has already mortgaged the future of our children.

The other thing the chairman said is that costs in health care will go down and that premiums will go down. Well, there are 11 out of 12 people who have studied ''the plan'' who say premiums will rise. What CBO says is, if you are in the individual market, your premiums are going to go up anywhere from 10 to 13 percent. In fact, they are not sure whether premiums will decline. They say on the other groups it is from a 1-percent increase to a 2-percent decrease over what they would have already increased.

So our problem with health care is costs. That is the thing that stops access to health care in this country. And the plan—whether it is the new plan, which nobody has gotten to see the details of, or the plan we have seen the details of, the 2,074 pages we have seen the details of—raises the cost of health care in this country.

But none of that is important because the most important thing is, it puts government in control of your health care through the task force on preventive health services, through the Medicare Advisory Commission, and through the cost comparative effectiveness panel. So with a wink and a nod we are going to put government in control of your health care; we are going to put 70 new bureaucracies between you and your doctor; we are going to put 20,000 new Federal employees between you and your doctor; and we are not going to lower the costs. The average American is not going to get a tax cut; they are going to see an

increase out of this bill. The average middle-income American is going to see a tax increase out of this bill.

So, consequently, what we have heard sounds good on the surface. But the most important thing to remember is you are no longer going to be in control of your health care because once the government puts its nose under the tent, just as it did on breast cancer screening—and we have the gall to say we are going to recognize every time the agency does something that is harmful to a patient in their relationship with their doctor, that we are going to come to the Senate floor and correct it. The fact is, that isn't going to happen.

So, ultimately, your health care is going to cost more and your premiums are going to rise. Eleven out of the twelve studies say premiums are going to rise under the bill that is before us, and the people who get the tax cuts are the people who aren't paying any taxes now. To pay for those tax cuts, taxes are going to rise on 40 million American families who earn under $200,000 a year.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Idaho.

Mr. CRAPO. Mr. President, I ask unanimous consent to speak, as well as engage in a colloquy with several of my colleagues.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. BAUCUS. Reserving the right to object, under the order of the day, what is the amount of time allocated to each side?

The ACTING PRESIDENT pro tempore. The Republicans control the next 30 minutes. Then the majority controls the next 30 minutes after that.

Mr. BAUCUS. I thank the Chair.

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

Mr. CRAPO. Thank you very much, Mr. President. I appreciate the opportunity to discuss the issue of taxes and jobs today as we focus on the critical legislation in front of us.

I have proposed an amendment, actually a motion, to commit this bill back to the Finance Committee to help us honor the President's pledge on taxes. As we have discussed now for more than a week, notwithstanding all of the claims that are being made about this legislation, one of the irrefutable facts is that it grows the government dramatically. If you take the first full 10 years of spending, not counting the first 4 years that are not included in the spending—in other words, they are delayed in order to make the numbers look better—if you count the first full 10 years of implementation of this bill, it will result in $2.5 trillion of new Federal spending. It will grow the Federal Government by that much.

Repeatedly, President Obama has told the American people he will not allow them to be taxed—those whom he describes as the middle class—in order to pay for this huge new increase in Federal spending.

To use President Obama's own words:

> I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase . . . not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes . . . you will not see any of your taxes increase one single dime.

Yet what does this bill do? It includes $493 billion of new taxes in just the first 10 years. If you use that full 10-year timeframe—that timeframe that starts after the 4 years of spending that have been suppressed in order to change the numbers and the calculations on the bill—the total number in that 10-year window is $1.2 trillion of new taxes.

The question is, Do these taxes fall only on the wealthy or do they fall squarely on those in the middle class? The answer is the large majority of them fall on the middle class. In fact, the Joint Tax Committee has indicated that by 2019, individuals earning between $50,000 and $200,000 would, on average, see a tax increase of $595,000. Families earning between $75,000 and $200,000 would, on average, see a tax increase of $670,000.

My colleague from Montana, the chairman of the Finance Committee, has argued that there is actually a net tax cut in the bill. How do we get to those numbers? Based on a Joint Committee on Taxation report, of the $394 billion that the government will spend on what are called tax credits—that is the tax cut that my colleague is talking about—$288 billion of those $394 billion in credits will go to people who pay no taxes today.

If you think about it, how can it be a tax cut if the money is spent from the Federal Treasury and sent to—or to somebody on behalf of—a person who is not paying taxes in the first place? You can call it a subsidy. You can call it a credit if you would like. I know the words used in the bill are a ''refundable tax credit,'' but the reality is it is nothing other than pure Federal spending. In fact, the Congressional Budget Office classifies this kind of benefit as government spending.

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

Mr. CRAPO. I will yield on the Senator's time.

Mr. BAUCUS. That is fine.

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

Mr. BAUCUS. The Senator says those are people who don't pay taxes. Don't most of those people pay a lot of taxes? Don't they pay payroll taxes, most of them, who work?

Mr. CRAPO. There is a payroll tax. There is.

Mr. BAUCUS. Are there not other taxes that people pay? It could be sales tax. There are all kinds of taxes that people pay. Particularly working people, there are a lot of taxes they pay.

Mr. CRAPO. Reclaiming my time, although people do pay a lot of sales taxes—not Federal sales taxes, by the way—and although people do pay a lot of other types of taxes, they will pay penalties and fees—in fact, under this bill they will be paying a lot more taxes. The reality is I don't think that is what President Obama was talking about. When he made his pledge, I think his words were: ''You will not see any of your taxes go up.'' The bottom line is you can't say, well, if you offset this tax and you don't count the sales tax or if you add in the sales tax to counteract it—that is not what the President was talking about.

Once again, as Joint Tax has said, by 2019 individuals making between $50,000 and $200,000 on average would see a tax increase of $590,000, and families making between $75,000 and $200,000 would see a net increase on average of $670,000.

Let's go to the next chart.

I note my colleague from Tennessee is here. If he would like to step in at any time, please feel free. I just have two other charts to show, and then I will toss the floor to the Senator. I see he has, I think, a question brewing.

In the analysis that was done by the Joint Tax Committee, by 2019, these people whose taxes I have just described who are squarely in the middle class, there will be at least 73 million American households—that is not individuals, that is households—73 million American households earning below the $200,000 that will face a tax increase. Sometimes the proponents of this bill say, well, that doesn't net out the subsidies we are providing to some of them. If you net out the subsidies—and I don't think that is necessarily an argument, but if you do net out the subsidies—it is still at least 42 million American households that will see their taxes increase under this legislation.

How can that comply with the President's promise? All the motion I have brought does is say to commit this bill to the Finance Committee and make the bill fit the President's pledge. The President pledged that people in the middle class, which he defined as families making less than $250,000 or individuals making less than $200,000, would not see their taxes go up.

With that, again, I see my colleague from Tennessee is ready to join in with me, and I would ask if he has any comments or questions to raise.

Mr. ALEXANDER. I thank the Senator from Idaho. The point you are making is, if you are going to add $½ trillion—this bill as proposed is paid for by about half through Medicare cuts and about half through tax increases, and it is paid for some by sending huge new bills to State governments. But I guess the point the Senator is making basically is that we are going to add $½ trillion in taxes over 10 years or much more than that when the bill is fully implemented. Who is going to end up paying those taxes? It is not going to be insurance companies. It is not going to be medical device

companies. It is going to be the people who—it is going to be us. Isn't that true? Don't you expect that most of the companies upon which the new taxes are imposed will pass those taxes along to the American people?

Mr. CRAPO. Yes. As a matter of fact, in my own mind, I distinguish between taxes on the American people and fees that will be charged to companies and businesses in the private sector that are also being passed on to the American people. All of those will occur.

One interesting clarification or explanation with regard to this refundable tax credit that is talked about so often: it isn't actually refunded to the taxpayer, as I understand it, or to the individual who doesn't pay taxes but is receiving the credit. It is paid directly to the insurance company, as I understand it. So even though some people could be claimed to be paying less taxes by this argument, because some of those who receive the subsidy will get a greater subsidy than they will a tax increase, the fact is even they still get a tax increase and even they still pay their taxes at the higher level. It is just that some of them will get a subsidy that will help to offset that.

Mr. ALEXANDER. I wonder if I may take a minute to talk about another form of taxes, which would be State taxes. Now, people might be thinking: Well, you are talking about a Federal health care bill. How do you get State taxes in there? Well, let me try to explain that just a little bit.

I remember as Governor of Tennessee some years ago, nothing used to make me madder than Washington politicians who would come up with a big idea, take credit for it, hold a press conference and announce it; call it, for example, historic, and then send the bill to me, the Governor, to pay it. Then usually those same politicians would come back to Tennessee and they would make a big speech about local control at the Jefferson Day dinner or the Jackson Day dinner. In fact, sometimes Republicans were just as bad as Democrats in doing it.

I also remember that in 1994 there was a political revolution in the country. This body switched dramatically to the Republican side, and one of the main arguments was no more unfunded mandates. In other words, don't be coming up with big ideas in Washington and sending the bill to the Governor or to the State legislature or to the mayor or to the county commission and expect them to raise property taxes or cut services or raise college tuitions to make it up.

So what I wish to say today is this: This legislation already includes a huge new bill for the State governments. As it is now written, Medicaid for low-income Americans is expanded, and there is a big bill to the States. Our Governor, who is a Democrat, by the way, has been very effective in pointing this out; that Senator REID's bill will add $700 million over 5 years to our State. There is no way our State can pay this bill without a tax increase of significant size or seriously damaging higher education or seeing college tuition begin to go through the roof, just as we saw it do in California the other day when it went up 32 percent. Why did it go up? Because the State has had to spend so much of its money on health care bills, many of which are required by the Federal regulations of Medicaid.

There is a rumor going around that there was a big deal cut last night that would pave the way for passage of this bill that says that instead of a new government-run program, we will simply expand two of the government-run programs we already have—Medicare for seniors and Medicaid for low-income Americans.

I would ask these questions: First, with Medicare, how in the world can we take $1 trillion out of Medicare when the program is fully implemented and give 34 million or 35 million more Americans a chance to opt in it at a time when the trustees of Medicare have said it is going broke in 5 years. Insofar as Medicaid goes, if it is true that the idea is to expand Medicaid to 150 percent of the poverty level—and, of course, we are not invited to any of the meetings; they were all written in the back room so we don't know the details—but if it is true we are going to expand Medicaid even more, our Governor has said in our State that doubles the cost of this legislation to our State.

So down the road, in a few years, what we are going to see in Tennessee is a new State income tax, seriously damaging higher education, and I think it is—

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

Mr. ALEXANDER. On your time, yes.

Mr. BAUCUS. I will quote from a letter basically to refute the allegations that this is a big obligation on the States. That is totally not true. The question is, Is it not true that on page 7 of the letter from the CBO, dated November 18, to Senator REID, CBO says:

> The CBO estimates that State spending on Medicaid would increase $25 billion over 10 years as a result of this legislation.

That is $2.5 billion a year, on average, for all States.

Another figure I know is that the State increase will not be huge but about a 1 percent increase over the State obligation. Why? Because, as the Senator also noted, an expansion of the population in Medicaid—the Feds are paying virtually all of it. But on a net basis, it is a 1-percent only increase in State obligation over 10 years. Does the Senator know that to be true?

Mr. ALEXANDER. My understanding of the proposal by the Finance Committee bill and by the Reid bill is that the Federal Government expands Medicaid and pays for 100 percent of it for a few years, but after that, the State has a significant portion of the bill. Am I not correct in that?

Mr. BAUCUS. We will have to divide this time. The division is correct. We are only talking—

Mr. ALEXANDER. I am not going to divide the time.

Mr. BAUCUS. Does the Senator ask a rhetorical question or an actual question?

Mr. ALEXANDER. Mr. President, I will retain the floor, and then the Senator can make his statement later.

The fact is, after 3, the Federal Government sends a big bill to the States. The fact is, the Governor of Tennessee, who is a Democrat and who has worked with other Governors and is actually leading the National Governors Association's effort to see the impact of this kind of legislation, says it will cost our State $700 billion over 5 years and $1.4 billion if we expand Medicaid up to 150 percent of federal poverty level. The State pays part of that bill. That means a big State tax increase. It means big higher education increases.

As a former Governor, I guarantee that if this happens, a few years from now when the federal government shifts costs onto the states, there will be a revolt in the States and people will be asking who did this. I would seriously say that any Senator who votes to expand Medicaid and sends a significant part of the bill to the States ought to be sentenced to go home and be Governor and try to govern the State under those conditions.

I think this kind of legislation, and especially the rumor I have heard regarding a dramatic increase in the expansion of Medicaid, will be a damaging blow to the American public's higher education from which it will never recover, tuition will go to a level where only the rich can afford to go to school, and the idea of public higher education will be left aside, all because Washington politicians ran up the bill, took the credit, made an announcement, and sent a huge bill to State governments that are struggling with their worst fiscal condition since the Great Depression.

Mr. CRAPO. I thank my colleague. We will see State taxes as well as Federal taxes going up.

Senator JOHANNS has joined us as well. Before I ask him to join in with questions and comments, I want to make one other clarification.

Again, we have the President's pledge up here on the chart. The motion I have offered simply says: Make the bill comply with the President's pledge. If there are no new taxes, the bill doesn't have to be changed if we pass this motion. If there are, it does.

Remember, I don't think that when the President made this pledge, he was saying he will not increase taxes on a net basis. In other words, I didn't hear the President say: I won't raise your taxes higher than I would cut them in some other areas. He specifically didn't say he would count subsidies being paid out to those who do not pay income taxes as an offset to any tax increases he wanted to raise somewhere else. The

President didn't get into all these nuances. He said he was not going to raise taxes on the middle class. The fact is, the middle class will see huge tax increases under this bill.

Before I toss the floor to my colleague, I will say this: CBO estimates that only 7 percent of all Americans will receive any of these subsidies. Yet, specifically, out of the 282 million Americans with some type of health insurance, only 19 million of them will be eligible for the tax credit for their health insurance. The rest of the millions of Americans are going to be the ones paying those taxes. That is how it ends up. At minimum—and we are still going through the bill, and this number is growing—at least 42 million people who make less than $200,000—and, frankly, far less—are going to be paying a lot more taxes. That is the reason for the motion.

I yield to my colleague, Senator JOHANNS.

Mr. JOHANNS. Mr. President, Senator ALEXANDER really has this right. I had the honor of being the Governor of Nebraska for 6 years. The whole idea of balancing a budget is not theoretical to a Governor. You have to do it.

Let me tell you, if I might, about our State. Many years ago—decades and decades ago—when our founders wrote our State constitution, they were worried about the State getting itself embroiled in too much debt. So they said the politicians will be allowed to borrow some money. The limit they put in the State constitution was $50,000.

So you see, in Nebraska, when you are faced with an unfunded mandate, like what is happening in this health care bill, I say you get three choices: You can cut programs like K–12 education, higher education, and much-needed services. No. 2, you can raise taxes, sales and income taxes. That is about what you are down to because that is really where the revenue comes from for States. The third choice is you get to do both. I guarantee you that none of those approaches is very popular.

Just within the last few weeks, our Governor, dealing with the recession, like every Governor in the country, stepped in front of the unicameral, as I did as Governor, and he said: My friends, we have to cut the spending. It was just as clear as can be. He said: We have to cut the spending. People are hurting. They are laid off. If they are hurting, they are not spending as much; therefore, our revenues are down. We have to cut spending.

They worked over a couple-week period of time, and they came up with a plan—I think it was unanimously approved—to cut the spending.

Well, here we are in Washington, and when you pull the gimmicks out of this bill and score it realistically over 10 years, this is a multimillion-dollar hit to every State, including the State of Nebraska. So what are we handing off to the State? Guess what. We are saying: You get a chance to raise taxes—not because of any vote you took on the floor of the unicameral in Nebraska but because of what happened with Washington unfunded Federal mandates. That is what this bill is all about when you look at the expansion of Medicaid. I read the reports about the possibility this might go to 150 percent. Keep doing the math, keep loading the unfunded mandates on our State Governors.

Do you know why we are doing this? We are doing it to try to convince the American people that this is a cheaper bill than it is. When they figure out that the Governor of their State has this problem to deal with and they come to figure out they are going to pay higher taxes or get fewer services and less education, it will become very real to them. I have said many times on this floor that with this bill, reality will set in. Here is another piece of reality.

Then you look at the overall bill. About $½ trillion—in addition to this Medicaid mess we are going to push onto the States, there will be about $½ trillion in new taxes.

Senator CRAPO put up the promise the President has made. Well, gee, when he is done with that board, we can ceremoniously tear it up because, you know what, that promise isn't anywhere near being kept. When he said those things, quite honestly, there was no way he could deliver with this health care bill. Uninsured Americans get taxed. Insured Americans get taxed. Families with high-value plans get taxed. High-health-cost families get taxed. Flexible spending gets reduced. Small businesses get taxed. We can go on and on and on, to the tune of $½ trillion. That is not even counting the unfunded mandate hammer we are sending to every Governor in this Nation.

Mr. CRAPO. Mr. President, I will add some statistics that I was reading while my colleagues were commenting. If you take out that CBO report, which is what actually analyzes this on a nonpartisan basis, the impact of these Medicaid expenditures, not including the proposed increase we heard about overnight, it clearly says:

> CBO estimates that State spending on Medicaid would increase by about $25 billion over the 2010–2019 period as a result of the provisions affecting coverage in table 3. That estimate reflects States' flexibility to make programmatic and other budgetary changes to Medicaid and CHIP.

That is the statistic my colleague from Tennessee was looking for.

Mr. ALEXANDER. I thank the Senator. It is true that in the legislation the estimate is that the Federal Government would pay 100 percent of the increased expansion of Medicaid for 3 years and that it will cover about 90 percent of the cost after that, which sounds like a lot. But we throw so much money around up here, we have completely lost any appreciation of what that amount of money costs at the State level. In our State, our Governor has said that the 133-percent increase is about $700 million over 5 years, and that is a big, new tax or a big increase in college tuition.

If I may, I ask unanimous consent to have printed in the RECORD an article from the Wall Street Journal of December 4 from the dean and CEO of Johns Hopkins Medicine.

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

[From the Wall Street Journal, Dec. 4, 2009]

HEALTH REFORM COULD HARM MEDICAID PATIENTS: A VAST EXPANSION OF THE PROGRAM WILL IMPOSE UNSUSTAINABLE COSTS ON TREATMENT CENTERS

(By Edward Miller)

BALTIMORE, MD.—Both the House and Senate health-care reform bills call for a large increase in Medicaid—about 18 million more people will begin enrolling in Medicaid under the House bill starting in 2013, Centers for Medicare and Medicaid Services (CMS) Actuary Richard Foster estimates.

We at Johns Hopkins Medicine (JHM) endorse efforts to improve the quality and reduce the cost of health care. But we also understand all too well the impact a dramatic expansion of Medicaid will have on us and our state—and likely the country as a whole.

A flood of new patients will be seeking health services, many of whom have never seen a doctor on more than a sporadic basis. Some will also have multiple and costly chronic conditions. And almost all of them will come from poor or disadvantaged backgrounds.

We know this because we've been caring for Medicaid patients in a managed-care setting for 14 years, as well as providing world-class care to people from all over the country and the world. Our experience provides a glimpse of the acute cost bubble that the health-care system will suffer with the reforms now being proposed.

Like Intermountain Healthcare in Utah, Geisinger Medical Center in Pennsylvania, and the Mayo Clinic, where, as President Barack Obama notes, ''people fly from all over the world to Rochester, Minnesota in order to get outstanding care,'' people also fly from all over the world to obtain care from JHM. But unlike those other institutions, we also serve large numbers of people who can't afford cab fare to the nearest hospital: poor, disadvantaged individuals, 150,000 of whom are in our Medicaid managed-care program, Priority Partners.

Priority Partners operates under a capitated system—that is, it receives a set payment per individual per month from the state. Over time, we've developed the ability to manage the care of these individuals in a way that is both cost effective and that provides them with quality care. We've done it by tapping into our extensive delivery system, which includes four hospitals, a nursing home, the largest community-based primary care group in Maryland, and much more.

We've hit above-national benchmarks on all clinical quality measures for our dialysis patients, reduced monthly costs for patients with substance abuse and highly complex medical needs, and 70% of our patients tell us they're satisfied with our care. But the learning curve has been costly and steep, and provides a cautionary tale for what will happen under the health-care reforms currently in Congress.

Mr. ALEXANDER. The dean, who writes a very sympathetic column which I will not read but a sentence or two of, is describing the current health care bill. He says:

Even if only half those individuals seek Medicaid coverage, such a large expansion would likely have an excruciating impact on the State's budget. And Maryland is not alone. According to a Kaiser Foundation survey conducted earlier this year, three-quarters of the States have expressed concern that expanding Medicaid could add to their fiscal woes. Already, as Kaiser notes, 33 States cut or froze payment rates to those who deliver health care to Medicaid patients. . . .

The proposal—and the Reid bill is maybe exacerbated by this deal we have been hearing about—is to shift millions more low-income Americans into a program called Medicaid, when only 50 percent of doctors will see new patients in that program, and then send a huge bill to the States, which will damage higher education.

I remember, after I was Governor, I heard on the radio that the State of Tennessee had done a wonderful thing. It would double the number of children covered by Medicaid at the same amount of cost. It went through my mind that it would never happen. That program became the TennCare Program, which has nearly bankrupted our State.

Mr. CRAPO. Mr. President, I thank my colleagues for their comments.

How much time remains on our side?

The ACTING PRESIDENT pro tempore. Six minutes.

Mr. CRAPO. I will make a couple of other comments, and I will allow my colleagues to wrap up with their final comments. I want to raise an additional issue.

On this chart, we show what is going to happen with the IRS. Right now, the CBO estimate indicates that because the IRS is in charge of the implementation of so many of the mandates and other requirements in this bill and because of the new taxes that will be forced onto the American people, there will need to be an expansion of the IRS. The CBO says that could mean as high as an additional $10 billion at the IRS.

If there are no new taxes in this bill or no new mandates in the bill, if there is no increased role of the Federal Government in the management of the health care economy in this bill, why do we need to have the size of the IRS, which is a $12 billion institution today—why does it need to grow to almost double, up to $22 billion?

The point is, the motion I have made is very simple and straightforward. We can argue back and forth about what the President said or whether this bill has tax cuts or tax increases in it or whether, in the net result, it does one thing or another.

The bottom line is, with regard to about 157 million Americans who get their health insurance through their employer, by 2019, they are not going to be eligible for these tax credits people are talking about. They are going to be paying increased taxes.

All this motion does is protect those 42 million people we were talking about who are going to see their taxes go up; 42 million households will see their taxes go up.

If the other side is right and what we are talking about does not exist in the bill, then this motion should be harmless because all the motion says is commit the bill to the Finance Committee and tell the Finance Committee to take out the taxes that impact the middle class.

I ask if either of my colleagues from Nebraska or Tennessee would like to make any concluding remarks.

Mr. JOHANNS. Mr. President, let me offer a thought or two. Senator CRAPO has hit the nail on the head. If this is not happening, if, in fact, the argument of the other side is accurate and this is not happening and this is some made-up sort of argument, then the Senator from Idaho is absolutely right, this motion will have no effect. So why would you not support the motion? Why wouldn't you want the health care bill to reflect the promise of the President of the United States? Why would you not stand and say: Look, it is a hard time out there. Unemployment is 10 percent. People are hurting. Unemployment and underemployment are 17.5 percent. This has been as tough a recession as we have seen in a long time, and it has hurt real people. Why wouldn't you want to stand for them and say: Man, we understand. We have heard you at our townhall meetings. We have heard you back home. We have heard you, and we are going to make sure we are not going to add to your burden.

I appreciate Senator ALEXANDER putting in that article. I thought that was a tremendous article. Medicaid is chewing up State budgets. I managed one of those budgets. Keep in mind, this is an entitlement program—no deductibles, no copays, no premiums. If you qualify, you get it. So there is no way you can manage this budget. It is exponentially growing. Forty percent of the docs do not take Medicaid patients. Why? Because they go broke on the reimbursement rate. Hospitals tell me all across the State of Nebraska: We cannot keep our doors open on the Medicaid reimbursement rate.

So what are we doing? We are adding millions of people to that problem. They will have an access problem. State budgets will have a problem. They will be in crisis. Our hospitals are going to face the same crisis. It is the wrong policy. It is the wrong course of action. Let's start listening to the American people.

Mr. ALEXANDER. Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. There is 1½ minutes remaining.

Mr. ALEXANDER. Mr. President, day in and day out Republicans have come to the floor and said: Instead of a comprehensive, 2,000-page approach to try to fix this massive health care system all at once in a way that raises taxes and premiums and makes Medicare cuts, why don't we, instead, identify the goal of reducing the cost of health care to individuals and to the government and take commonsense steps toward that goal.

We have suggested small business health care plans which have been offered, scored by the CBO to save money and expand coverage. We have offered proposals to limit the number of junk lawsuits against doctors. There may be an argument about how much that saves, but there is no argument that would not drive down the costs. We have suggested allowing purchasing of health insurance across State lines to increase competition, and creating health insurance exchanges. There are efforts in wellness and prevention that we have made specific proposals concerning. In terms of corralling waste, fraud and abuse in Medicare and then spending the savings on Medicare, instead of a new program, that is the Republican agenda.

Pick a goal: reducing health care costs and move step by step toward that goal in a way that reearns the trust of the American people, instead of a comprehensive, 2,000-page bill filled with taxes, mandates, surprises, and a Washington takeover of health care.

There is a real choice. We regret the fact that we seem to be continuing to move on this track without the track we are offering. We want to defeat what is proposed, not in the debate. Change the debate toward reducing costs step by step.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, the Senator from Oklahoma and others on the other side of the aisle make the charge this bill increases government. That is not so. It does not increase government. This bill does not increase government. They made that allegation. It is a pure allegation. Anybody can allege anything, but let me get the facts. It is one thing to make an allegation; it is something else to get the facts.

The best fact I have come up with is a quote from the Congressional Budget Office letter to Senator REID on that point. The Congressional Budget Office says—and I quote from page 16 of the letter. I do not have the date of the letter. There are several letters to several of us in the Senate. I will quote the letter. It says:

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

''Roughly balance out.'' ''No significant change in that commitment.'' That does not sound like an explosive growth in government to me. In fact, it sounds the opposite, listening to the Congressional Budget Office.

Also, add to that this bill, in the first 10 years, decreases the deficit by $130 billion. But CBO says: No, no, no significant change. Things will roughly balance out, according to the Congressional Budget Office.

Mr. CRAPO. Mr. President, will the Senator yield for a question?

Mr. BAUCUS. This controls the government's role in health care. It does not increase it.

I do not have any time, I say to the Senator from Idaho. We are an hour later—if we have another time agreement, we will take it out of the Senator's time. I will be willing to yield if the Senator from Idaho has a question.

Mr. CRAPO. No, I will ask a question later, then.

Mr. BAUCUS. Fine. Some of my colleagues on the other side of the aisle try to paint health care reform as bad for the economy. Nothing could be further from the truth. Health care reform will be good for the economy. Health care reform is a net tax cut for working Americans—a net tax cut. Health care reform is essential for long-term growth.

Some say it is a tax increase. It is not. The Congressional Budget Office—I have a chart right in front of me—a net tax cut. If you take all the provisions of this bill that affect individuals, the Joint Committee on Tax concludes that the average tax break for affected filers with income under $75,000 is a cut every year. I will take one year, 2019: a $1,500 cut for those people in that category. Net tax break for affected overall is a $441 decrease. It is a long chart. I will not take the time to read it all.

In summarizing the chart, affected taxpayers, as a percent of all taxpayers—it is over a majority—will see a net tax cut.

Some say for some it will be a tax increase. Let me indicate why that is somewhat true. They are getting more wages. Of course, their taxes go up if they get more wages. Why are they getting more wages? Because these tend to be people affected by so-called Cadillac plans. The Joint Committee on Tax and the Congressional Budget Office say in that category, premiums go down and wages go up. Obviously, taxes are going to go up when wages go up. It is not fair to say that taxes are going up for those folks in that category unless you also say it is largely because their income is going up. I think that should be pointed out as well.

Our bill will provide a substantial tax cut. It will cut taxes by $40 billion in 2017 alone and cut taxes by $40 billion in 2019 alone and by substantial net tax cuts year after year. The average affected taxpayer with an income under $75,000 a year would get a tax cut of more than $1,500 in 2019. The bill would affect more than 92 million taxpayers a year by 2019. That is reductions. Our bill would affect most taxpayers by 2017, and the bill would give average taxpayers affected hundreds of dollars of tax relief.

Not only would health care reform cut taxes for working Americans, it would also address the single largest challenge to our long-term fiscal future.

Reforming health care is the single most important thing we can do to address long-term budget deficits. The Congressional Budget Office says we will succeed in doing that. CBO says our bill would reduce the Federal budget deficit by $130 billion in the first 10 years. CBO says our bill would reduce the budget deficit by roughly $650 billion in the second 10 years. That is roughly $780 billion in net deficit reduction. That is $800 billion in net deficit reduction over 20 years. I think that is progress. That is pretty good.

Some of my colleagues say: Gee, Medicaid is pretty expensive, so be careful, Congress, with what you do with respect to imposing obligations on States. I remind my colleagues there currently is a formula each State must subscribe to with respect to Medicaid. The Federal Government pays a certain portion and States pay the other. On average—I could be off—the Federal Government pays 50 to 60 percent and the States pay the rest.

Under this legislation, we are talking about the so-called transitional group, those where the poverty level is raised, in that category—I have forgotten the exact figure. But it is not the old formula, it is the new formula. Under the new formula, the Federal Government is paying virtually all of it—not quite all but virtually all of it. So the States will get a little bit of an increase in obligations. It is small. It is infinitesimal.

The underlying point is, we have to reform health care. Why do Medicaid costs go up? Because health care costs are going up around the country—health care costs for seniors, low-income people, health care costs for everybody.

There are so many parts of this bill which address that problem, which address health care costs, to get health care costs down. I would think all State Governors would want this bill to pass. Why? Because we are going to begin to go down the road of lowering health care costs. Then those Medicaid budgets will be more under control.

We have to lower health care costs, and this legislation does that. Health care reform would very much help the economy, not just in the near term but with substantial net tax cuts but also help the economy long term with substantial deficit reduction—but also all the provisions we are putting in to lower health care costs overall.

It is, clearly, the right thing to do. I, therefore, believe this legislation should definitely pass. To remind my colleagues who say: Gee, for folks making more than $250,000 a year, they will pay more taxes, let me make clear: Those folks are not seeing tax rate increases. Those folks are going to pay more taxes because they are going to get pay raises. That is why they are going to pay more taxes because, in effect, their incomes are going to go up. They are going to get pay increases.

I have more to say, but I see my colleague from Vermont on the floor. How much time is remaining on in this block?

The ACTING PRESIDENT pro tempore. There is 19½ minutes remaining.

Mr. BAUCUS. I yield 15 minutes to my friend from Vermont.

Mr. SANDERS. Mr. President, I thank the chairman for yielding. Before I get into the subject I wish to talk about, which is prescription drug reimportation and the absolute necessity of lowering the cost of prescription drugs in this country, I wish to say a word in general.

I find it interesting that my Republican friends are spending a whole lot of time down here on the floor attacking the health care legislation. I suppose it is at least a positive thing that they are beginning to talk about health care. They ran the government from 2000 to 2006. They had the President, they had the House and the Senate. At that time, health care premiums soared. Millions of Americans lost their health insurance. Where were they? Where were they in the beginning to come up with ideas to control health care costs and provide health care to more Americans? They weren't there.

Now, having said that, let me also say I have problems with the bill that is currently on the Senate floor. Clearly, it does a lot of things that are good, but there are weaknesses in this bill in terms of cost containment that we have to address.

When some of my friends talk about expanding Medicaid and the problems associated with that, they make a good point. We need to significantly expand our primary health care capabilities, which means more community health centers, which means more primary health care physicians. If we are not able to do that while we add 15 million more people to Medicaid, frankly, I am not sure how we are going to deal with the medical needs of those people.

So I think one of the imperatives that has to happen as we proceed on this bill is we have to support the language in the House, which substantially increases funding for community health centers and for the National Health Service Corps, so that we give a primary health care infrastructure—clinics and doctors—to begin to serve the millions more Americans who are going to be coming into the health care system.

That is one issue. The other issue I wanted to focus on today—and I am here because Senator DORGAN, who is the sponsor of this legislation, is unable to be on the floor of the Senate at this time—deals with prescription drug reimportation. This is an issue I have worked on for many years. When I was Vermont's Representative in the U.S. House, I believe I was the first Member of Congress to take American citizens over the Canadian border—in this case to Montreal—in order to purchase affordable prescription drugs.

I will never forget—never forget—the bus trip we took over from St. Albans, VT, to Montreal, Canada. On that bus there were a number of lower income

women who were struggling with breast cancer. Many of them were using the widely used breast cancer drug called Tamoxifen. We got off the bus in Montreal, and we walked into the drugstore—and that had all been prearranged—and in there they purchased Tamoxifen. At that point in time—and I am thinking it was about 10 years ago, a while back—they paid, in American dollars, one-tenth of the price for Tamoxifen in Montreal, Canada, that they were paying in the United States of America—one-tenth of the price for lower income women who were struggling for their lives.

So when you talk about morality, I want some of my friends to explain why it is that the American people are forced to pay by far the highest prices in the world for prescription drugs? Talk to physicians in Vermont. There is a doctor I know in northern Vermont, and when she writes a prescription, one-third of her patients cannot afford to fill the prescription. So what is the sense of an examination, a diagnosis, and writing a script when your patient can't even fill that script?

The high cost of prescription drugs in this country is one of the major health care crises we face. It is an issue we have to deal with, and we simply have to ask ourselves why it is that the same exact medicine in this country costs substantially more than it does in Canada, in Australia, or all over Europe.

There has been a lot of concern in this country about the lack of bipartisanship. Well, I have to say that on this issue there is bipartisanship. That was true when I was in the House, and that is true in the Senate.

Let me just read to you the cosponsors of this legislation—Democrats, Republicans, Independents. The bill is introduced by Senator DORGAN, and the cosponsors are Senator BEGICH, Senator BOXER, Senator CASEY, Senator CONRAD, Senator FEINGOLD, Senator INOUYE, Senator KLOBUCHAR, Senator LEAHY, Senator LINCOLN, Senator MCCASKILL, Senator SANDERS, Senator SNOWE, Senator STABENOW, Senator THUNE, Senator BINGAMAN, Senator BROWN, Senator COLLINS, Senator DURBIN, Senator GRASSLEY, Senator JOHNSON, Senator KERRY, Senator KOHL, Senator LEVIN, Senator MCCAIN, Senator NELSON, Senator SHAHEEN, Senator SPECTER, Senator TESTER.

So there is widespread bipartisan support for legislation which says: Let's end the absurdity of the American people having to pay substantially more for the same exact medicine that is sold in other countries around the world.

Let's take a look at some of these charts. To begin with, we all understand when you deal with the drug companies and the pharmaceutical industry you are dealing with some of the most powerful lobbyists and forces right here in Washington, DC. These people spend huge amounts of money on campaign contributions, huge amounts of money in lobbying. Just recently, in order to make sure they got in under the wire, in case there was some real reform passed in Washington, they substantially raised their prices for particular drugs just in the year 2009, and here is the chart reflecting that: Enbrel, a 12-percent increase; Singulair, 12 percent; Plavix, 8 percent, Nexium, 7 percent; Lipitor, 5 percent; Boniva, 18 percent.

One of the reasons health care costs are soaring in America—and one of the reasons many seniors are having such a difficult time with health care costs—is precisely the rapid rise of prescription drugs.

What I want to talk about now, through this chart, is something that is inexplicable to the average American. This is Lipitor, which is a widely used drug, and here is the cost of Lipitor. The same amount in Canada costs $33; in France, $53; Germany, $48; the Netherlands, $63; in Spain, $32; the United Kingdom, $40; and in the USA, $125, or four times as much as it costs in Canada.

Now, you explain that to me. The same exact medicine made in the same exact factory, the same exact bottle. That is why, by the way, in the State of Vermont, and all across the northern tier, every day people are going over the Canadian border or using the Internet to buy those drugs. So what we are saying in this legislation is let's end this absurdity.

We are living in a global economy. I have a lot of problems with the global economy in many ways, but if, when we go Christmas shopping, the only products we can find are made in China—because we don't do too much manufacturing in America—and if when we eat lunch we get lettuce and tomatoes from all over the world, what people are asking is, why is it we can't bring into this country FDA-safety-approved medicine? We can bring lettuce in from the backwoods of Mexico, and that is OK. But somehow, when we have a handful of major pharmaceutical companies, presumably it is just too difficult to be able to bring them safely into the United States. Nobody believes that for one moment.

Let's take a look at another chart. Plavix, same story: Canada, $85; France, $77; Germany, $85; the Netherlands, $77; Spain, $58; the U.K. $59; and in the USA, $133. Somebody explain this to me. I really would appreciate it.

Nexium: Canada, $65; Germany, $37; Spain, $36; the UK, $41; and the United States of America, $424. That is six times more than in the United Kingdom. People wonder why Americans are running over the Canadian border or they are on the Internet trying to get this medicine.

Why is it that the drug companies charge $424 here and $41 in the UK? Well, the reason they are charging more here is because they can charge more. If you walk into your drugstore tomorrow, you can find the prices that you will pay are double, triple because we are the only country in the world that does not have, in one way or another, some kind of regulation on prices. All these other countries have national health care programs. That is another reason their drug prices are lower. We don't, of course.

But at the very least, what reimportation is all about is, we are saying, in a global economy, when all kinds of products are brought in from all over the world and we let the consumer buy them every day, why not let the pharmacist, let the prescription drug distributor be able to take advantage of the global economy?

I am not, I must confess, a great supporter of unfettered free trade. I think that has, in many ways, been a disaster for American workers. But to the degree that it is here, to the degree businesspeople can run to China and pay workers there 50 cents an hour or so, that is the global economy. Well, here is the global economy: Canada, $65; the UK, $41; and the USA, $424. Why can't prescription drug distributors purchase their products in the UK, bring them back into America, so we can substantially lower the cost of health care and prescription drugs for all Americans?

Some of my friends in the pharmaceutical industry say: It is impossible to bring medicine in from abroad. It can't be done safely. Well, the Washington Post says:

> 40 percent of active ingredients in U.S. prescription drugs currently come from India and China.

I guess that is OK for the pharmaceutical industry, when it adds to their profits, but we can't do that to lower the cost to the consumer.

The Wall Street Journal, February 21, 2008, says:

> More than half the world's Heparin, the main ingredient in the widely used anti-clotting medicine, gets its start in China's poorly regulated supply chain.

Well, I guess that is OK too.

So here is where we are. One of the many health care crises we face in this country is the high cost of prescription drugs. I think there is a lot that we have to do. Whether the Congress is capable of standing up to the drug companies and all their money and all of their lobbyists remains to be seen. But this is, quite frankly, a no-brainer.

For all my colleagues here who believe in unfettered free trade, please do not be total hypocrites. If you believe in unfettered free trade—which I happen not to—if you believe it is OK for American companies to shut down and run to China, if you think it is OK for people to buy any product anywhere in the world, tell me why we can do that for everything except for prescription drugs? There is no rational explanation.

This is legislation which has been around for years. The drug companies have fought it successfully for years. We now have widespread tripartisan

support in the Senate and a lot of support, I know, in the House. Let's finally stand up for the average American. Let's substantially lower the cost of prescription drugs. Let's pass prescription drug reimportation.

With that, Mr. President, I yield the floor, and I suggest the absence of a quorum.

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

The assistant bill clerk proceeded to call the roll.

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

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

Mr. MCCAIN. Is there a previous agreement on time?

The ACTING PRESIDENT pro tempore. The next hour is equally divided, with 10-minute limits.

AMENDMENT NO. 2793

Mr. MCCAIN. Mr. President, I rise on behalf of the amendment which, according to the Congressional Budget Office, would provide an estimated $100 billion or more in consumer savings over 10 years. That is unique to this bill. It is unique to this legislation. It actually saves the taxpayers money.

I think it is important for us to go back and see how we got here—again, with the administration and the President reversing his previous position in favor of drug reimportation, the President's Chief of Staff, Mr. Rahm Emanuel, reversing his position on drug reimportation.

Again, a lot of it has to do with the deals that have been made. I refer, to start with, to the August 6, 2009, New York Times article.

Pressed by industry lobbyists, White House officials on Wednesday assured drug makers that the administration stood by a behind-the-scenes deal to block any Congressional effort to extract cost savings from them beyond an agreed-upon $80 billion.

Then it goes on to say:

''We were assured: We need somebody to come in first. If you come in first, you will have a rock-solid deal,' Billy Tauzin, the former Republican House member from Louisiana who now leads the pharmaceutical trade group, said Wednesday. ''Who is ever going to go into a deal with the White House again if they don't keep their word? You are just going to duke it out instead.''

The pressure from Mr. Tauzin to affirm the deal offers a window on the secretive and potentially risky game the Obama administration has played as it tries to line up support from industry groups typically hostile to government health care initiatives, even as their lobbyists pushed to influence the health measure for their benefit.

Here is the important part of the article—and I ask unanimous consent the entire article from the New York Times be printed in the RECORD.

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

[From the News York Times, Aug. 6, 2009]

WHITE HOUSE AFFIRMS DEAL ON DRUG COST

(By David D. Kirkpatrick)

WASHINGTON.—Pressed by industry lobbyists, White House officials on Wednesday assured drug makers that the administration stood by a behind-the-scenes deal to block any Congressional effort to extract cost savings from them beyond an agreed-upon $80 billion.

Drug industry lobbyists reacted with alarm this week to a House health care overhaul measure that would allow the government to negotiate drug prices and demand additional rebates from drug manufacturers.

In response, the industry successfully demanded that the White House explicitly acknowledge for the first time that it had committed to protect drug makers from bearing further costs in the overhaul. The Obama administration had never spelled out the details of the agreement.

''We were assured: 'We need somebody to come in first. If you come in first, you will have a rock-solid deal,''' Billy Tauzin, the former Republican House member from Louisiana who now leads the pharmaceutical trade group, said Wednesday. ''Who is ever going to go into a deal with the White House again if they don't keep their word? You are just going to duke it out instead.''

A deputy White House chief of staff, Jim Messina, confirmed Mr. Tauzin's account of the deal in an e-mail message on Wednesday night.

''The president encouraged this approach,'' Mr. Messina wrote. ''He wanted to bring all the parties to the table to discuss health insurance reform.''

The new attention to the agreement could prove embarrassing to the White House, which has sought to keep lobbyists at a distance, including by refusing to hire them to work in the administration.

The White House commitment to the deal with the drug industry may also irk some of the administration's Congressional allies who have an eye on drug companies' profits as they search for ways to pay for the $1 trillion cost of the health legislation.

But failing to publicly confirm Mr. Tauzin's descriptions of the deal risked alienating a powerful industry ally currently helping to bankroll millions in television commercials in favor of Mr. Obama's reforms.

The pressure from Mr. Tauzin to affirm the deal offers a window on the secretive and potentially risky game the Obama administration has played as it tries to line up support from industry groups typically hostile to government health care initiatives, even as their lobbyists pushed to influence the health measure for their benefit.

In an interview on Wednesday, Representative Raul M. Grijalva, the Arizona Democrat who is co-chairman of the House progressive caucus, called Mr. Tauzin's comments ''disturbing.''

''We have all been focused on the debate in Congress, but perhaps the deal has already been cut,'' Mr. Grijalva said. ''That would put us in the untenable position of trying to scuttle it.''

He added: ''It is a pivotal issue not just about health care. Are industry groups going to be the ones at the table who get the first big piece of the pie and we just fight over the crust?''

The Obama administration has hailed its agreements with health care groups as evidence of broad support for the overhaul among industry ''stakeholders,'' including doctors, hospitals and insurers as well as drug companies.

But as the debate has heated up over the last two weeks, Mr. Obama and Congressional Democrats have signaled that they value some of its industry enemies-turned-friends more than others. Drug makers have been elevated to a seat of honor at the negotiating table, while insurers have been pushed away.

''To their credit, the pharmaceutical companies have already agreed to put up $80 billion'' in pledged cost reductions, Mr. Obama reminded his listeners at a recent town-hall-style meeting in Bristol, Va. But the health insurance companies ''need to be held accountable,'' he said.

''We have a system that works well for the insurance industry, but it doesn't always work for its customers,'' he added, repeating a new refrain.

Administration officials and Democratic lawmakers say the growing divergence in tone toward the two groups reflects a combination of policy priorities and political calculus.

With polls showing that public doubts about the overhaul are mounting, Democrats are pointedly reminding voters what they may not like about their existing health coverage to help convince skeptics that they have something to gain.

''You don't need a poll to tell you that people are paying more and more out of pocket and, if they have some serious illness, more than they can afford,'' said David Axelrod, Mr. Obama's senior adviser.

The insurers, however, have also stopped short of the drug makers in their willingness to cut a firm deal. The health insurers shook hands with Mr. Obama at the White House in March over their own package of concessions, including ending the exclusion of coverage for pre-existing ailments.

But unlike the drug companies, the insurers have not pledged specific cost cuts. And insurers have also steadfastly vowed to block Mr. Obama's proposed government-sponsored insurance plan—the biggest sticking point in the Congressional negotiations.

The drug industry trade group, the Pharmaceutical Research and Manufacturers of America, also opposes a public insurance plan. But its lobbyists acknowledge privately that they have no intention of fighting it, in part because their agreement with the White House provides them other safeguards.

Mr. Tauzin said the administration had approached him to negotiate. ''They wanted a big player to come in and set the bar for everybody else,'' he said. He said the White House had directed him to negotiate with Senator Max Baucus, the business-friendly Montana Democrat who leads the Senate Finance Committee.

Mr. Tauzin said the White House had tracked the negotiations throughout, assenting to decisions to move away from ideas like the government negotiation of prices or the importation of cheaper drugs from Canada. The $80 billion in savings would be over a 10-year period. ''80 billion is the max, no more or less,'' he said. ''Adding other stuff changes the deal.''

After reaching an agreement with Mr. Baucus, Mr. Tauzin said, he met twice at the White House with Rahm Emanuel, the White House chief of staff; Mr. Messina, his deputy; and Nancy-Ann DeParle, the aide overseeing the health care overhaul, to confirm the administration's support for the terms.

''They blessed the deal,'' Mr. Tauzin said. Speaker Nancy Pelosi said the House was not bound by any industry deals with the Senate or the White House.

But, Mr. Tauzin said, ''as far we are concerned, that is a done deal.'' He said, ''It's up to the White House and Senator Baucus to follow through.''

As for the administration's recent break with the insurance industry, Mr. Tauzin said, ''The insurers never made any deal.''

Mr. MCCAIN. The important quote is:

Mr. Tauzin said the administration had approached him to negotiate. ''They wanted a big player to come in and set the bar for everybody else,'' he said. He said the White

House had directed him to negotiate with Senator Max Baucus, the business-friendly Montana Democrat who leads the Senate Finance Committee.

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My goodness.

''They blessed the deal,'' Mr. Tauzin said.

That is how we got here, with the administration coming over with a letter last night basically saying they would oppose or certainly impede the ability of Americans to import drugs from Canada. What have we seen happen in the interim? Here again is a New York Times article entitled ''Drug Makers Raise Prices in Face of Health Care Reform.''

Here is a graphic demonstration of it. This little line right here, I would say to my colleagues, is inflation in this country. If you look at it for the year 2009, inflation is actually minus 1.3 percent.

Now look at the wholesale drug prices. The annual change is 8.7 percent. While inflation has gone down 1.3 percent, actual costs of drugs have gone up 8.7 percent.

The article from the New York Times says:

Even as drug makers promise to support Washington's health care overhaul by shaving $8 billion a year off the nation's drug costs after the legislation takes effect, the industry has been raising its prices at the fastest rate in years. In the last year, the industry has raised the wholesale prices of brand-name prescription drugs by about 9 percent, according to industry analysts. That will add more than $10 billion to the nation's drug bill. . . .

Let's get the math right. The drug companies have offered to save the American consumer $8 billion a year, and guess what. They have increased their prices, where it will add more than $10 billion to the drug bill of America's citizens, including our seniors.

The math is, they agreed to an $8 billion reduction. They actually already this year have seen an increase of more than $10 billion. So they are on track to make a $2 billion profit off their deal. No wonder they made a deal.

That will add more than $10 billion to the nation's drug bill, which is on track to exceed $300 billion this year. By at least one analysis, it is the highest annual rate of inflation for drug prices since 1992. . . .

This is the consumer price index right here, which has fallen by 1.3 percent.

Drug makers say they have valid business reasons for the price increases. Critics say the industry is trying to establish a higher price base before Congress passes legislation that tries to curb drug spending incoming years.

That is what this is all about. They increase the prices so it reaches a certain level, and that is what they will negotiate on. They already are in line to experience $2 billion more in profits than the $8 billion they say they intend to cut. What a Ponzi scheme this is.

''When we have major legislation anticipated, we see a run-up in price increases,'' says Stephen W. Schondelmeyer, a professor of pharmaceutical economics at the University of Minnesota. He has analyzed drug pricing for AARP, the advocacy group for seniors that supports the House health care legislation that the drug industry opposes.

A Harvard health economist, Joseph P. Newhouse, said he found a similar pattern of unusual price increases after Congress added drug benefits to Medicare a few years ago, giving tens of millions of older Americans federally subsidized drug insurance. Just as the program was taking effect in 2006, the drug industry raised prices by the widest margin in a half-dozen years.

We have seen this scam before. What is the administration going to do? The administration sends a letter, I believe last night—not to the sponsor of this legislation, Senator DORGAN, but to another Member basically saying they would have to examine the health and safety.

Since when is a prescription drug imported from Canada a threat to Americans' health, since they obviously have the same standards that we do? The letter is to Senator CARPER. It is signed by Margaret Hamburg, Commissioner of Food and Drugs. It is—I am not making this up. I am not making this up. ''The Dorgan importation amendment seeks to address these risks.'' It talks about our amendment.

We commend the sponsors for their efforts to include numerous protective measures in the bill that address the inherent risks of importing foreign products and other safety concerns relating to the distribution system for drugs within the U.S. However, as currently written, the resulting structure would be logistically challenging to implement and resource intensive.

Let's get this straight. According to the CBO, if we pass this, we would save consumers $10 billion—excuse me—$100 billion. According to CBO, we would provide an estimated $100 billion in consumer savings over 10 years. That is what the CBO says.

But what this obviously heavily overburdened Margaret Hamburg, the Commissioner of Food and Drug, says is:

However, as currently written, the resulting structure would be logistically challenging to implement and resource intensive.

Oh my God. I am going to have to include, for the RECORD, the number of employees over at the Food and Drug Administration. I am sure they are full up with their responsibilities at present.

In addition, there are significant safety concerns related to allowing the importation of non-bioequivalent products, and safety issues relating to confusion in distribution and labeling of foreign products—

When we see something come in from foreign countries, it is so confusing when you look at the labeling of it. It is remarkably challenging for the American consumer——

relating to the distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

''But''—she goes on to say, to Senator CARPER, who is a fine and great Member of this body but not the sponsor of the amendment——

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

Mr. MCCAIN. I ask for an additional 30 seconds to finish.

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

Mr. MCCAIN. ''We appreciate your fine leadership on this important issue and would look forward to working with you as we continue to explore policy options to develop an avenue for the importation of safe and effective prescription drugs from other countries.''

Translated: The fix is in. We will be back on the floor on this. I strongly urge the adoption of the amendment.

I yield the floor.

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

Mr. NELSON of Florida. Mr. President, I am back on the floor on this, as I have been over the course of the last decade, because we have been like a yo-yo in my State of Florida on the importation of drugs, since we have quite a few senior citizens in our State. They have been accustomed to either going to Canada and bringing back prescriptions at half the price or phoning Canada to pharmacies and having those drugs shipped in the Postal Service or e-mailing to Canadian pharmacies. What happened over the course of the last 8 or 9 years is that the previous administration cracked down on the reimportation of these drugs. Of course, that was at a great expense to our senior citizens who can buy these drugs at roughly ½ of what they pay by going into the pharmacies in the United States.

Then an interesting thing happened along about 2006. This Senator started getting multiples of calls—I think up to something like 100 complaints in that 1 year from senior citizens who had purchased the drugs, either by e-mail, telephone, or by going personally there and having them shipped. And lo and behold, under the previous administration, they gave the order to the Postal Service to confiscate these drugs. This happened, for example, to a couple from Mt. Dora, FL, Mr. and Mrs. Lee Eads. They had their drugs confiscated. We went after the Postal Service. We went after the Customs Bureau. We found, in fact, that a lot of these complaints we had received, those drugs had been confiscated when, in fact, the policy was supposed to be if it was pharmaceuticals for personal use—and they defined that as less than a 90-day supply—the government, the U.S. Government, was going to let these senior citizens take advantage of getting that cost break of a 50-percent reduction.

It took us till late 2006—getting into this with Mr. and Mrs. Eads as the poster couple who had been getting their prescription drugs and then, all of

a sudden, they were confiscated—to get the Postal Service and Customs to reverse. This has supposedly been the policy, but we can't get it etched into law because people keep bringing up this Trojan horse that it is not safe. The very manufacturers we are buying our prescriptions from here in American pharmacies are the same manufacturers in identical locations with identical labeling of the drugs that are going to Canadian pharmacies. Why can't we give our senior citizens a break?

Of course, what this Senator would like to do is to give them a bigger break. This Senator has an amendment, which is continuously being stated that I may not get to offer, that would cause the pharmaceutical industry to give discounts on the drugs sold under Medicare that are being sold to 6 million people who are eligible because of their low income for Medicaid but get their drugs through Medicare. Those 6 million people, Medicaid, poor people who are eligible to get government assistance, used to have a discount, a substantial discount. Therefore, the U.S. Government was paying less for the drugs it bought for those people. But 6 years ago, when the prescription drug benefit was passed, those 6 million people were suddenly made ineligible to get the drug discount because they were now getting their drugs under Medicare. That is absolutely ridiculous, that the U.S. Government is going to pay full price for the drugs now that they used to pay only a fraction.

How much is that worth? According to CBO and the amendment I offered in the Finance Committee that was defeated 10 to 13, that is worth $106 billion over 10 years that would be savings to the American taxpayer that we would be paying for those dual eligibles, Medicaid recipients who get their drugs in Medicare, $106 billion of savings that the U.S. Government would not have to pay for those drugs, if we followed the same policy we did back there before this prescription drug benefit for Medicare.

That kind of makes common sense, doesn't it, that we would want to save the American taxpayer $106 billion? But we were defeated by a vote of 13 opposed to the amendment and 10 in favor in the Finance Committee.

I know it is a tall order to bring this amendment out here on the floor and have to meet a 60-vote threshold, because 41 Senators can deny the American taxpayer from getting $106 billion of savings. One of the good things about our bill that has come to the floor is, we are going to reduce the deficit by $130 billion. That is over a 10-year period. That is a good thing. But if we would accept my amendment, we could reduce the deficit by $236 billion or we could use part of it—say, half—to fill the rest of the doughnut hole that the AARP would like and so would this Senator. The AARP strongly supports my amendment. They have made it clear to the leadership of this Senate that they want to see that doughnut hole closed. But there is nothing coming out here on the floor that is going to do that.

The amendment Senator DORGAN has offered, which in and of itself is good policy, reimporting drugs at half the cost from Canada, is a step in the right direction, but that doesn't close the doughnut hole.

So here we are at a decision point. Who are we going to serve? Let me say at the outset I understand the political dynamics. I want to give credit where credit is due. The pharmaceutical industry is, in fact, supporting the leadership in trying to pass this bill. That is a good thing. We appreciate that very much. We need their support because we have all these other interest groups that are flaking off. At the end of the day, we have to get 60 votes in order to pass health care reform. That includes health insurance reform. We have the insurance industry totally, flat out trying to kill this legislation. I am grateful to the pharmaceutical industry for trying to help us. Therefore, my plea is, there has to be a balance. There has to be a compromise in the works. There has to be a way of the pharmaceutical industry stepping to the plate to help us totally fill the doughnut hole, that gaping $3,000 hole seniors have to pay for all of the drugs they need when they reach that level. There has to be a sweet spot, a compromise.

I certainly support the Dorgan amendment. I hope the Senate will favorably consider my amendment later on.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS.) The Senator from Texas.

Mrs. HUTCHISON. How much time remains on our side?

The PRESIDING OFFICER. There is 19 minutes on the Republican side and Senators are limited to 10 minutes each.

Mrs. HUTCHISON. I thank the Chair.

Mr. President, we have been talking about the Crapo motion and the new taxes that are in this bill. There are so many new taxes that it is going to increase the cost of health care to every individual who has health insurance. It will also tax the people who don't have health insurance. It will tax the people who have too much health insurance. The taxes in this bill are almost mind-boggling.

Yesterday we talked about the cuts in Medicare. But we are also talking now about the $½ trillion in tax increases, $500 billion of tax increases. What Senator CRAPO's motion will do is to say that we want to go back to the promise made by the President that no one who makes under $200,000 or a couple who makes under $250,000 would have any tax increases. It recommits the bill and takes out everything that would tax individuals at that level because the promise was made to the American people.

Senator CRAPO's motion would certainly benefit those who have high-benefit plans which are going to have a 40-percent excise tax in this bill. If your plan is considered high benefit and you make under $200,000 a year or you are a couple making under $250,000 a year, you should not have to pay, because your benefits are better than the government has said they should be.

We would help the union member, for instance, because the unions do have high-benefit plans. We would help those union members who are making under $200,000 a year, if they are single, to make sure that they are not going to pay a tax for having too much coverage. Then there are the individuals who have no coverage or too little coverage who are going to have to pay an individual tax in this bill of $750. Surely if someone can't afford to have health insurance, we should not be taxing them. The Crapo motion will assure that when this goes back to the committee, someone would not be subject to the individual mandated tax, if they make under $200,000 a year, which they surely probably do, or if they have a high-benefit plan and they make under that amount. It is trying to say that promise that the President made would be kept.

I also wish to talk about another issue in this bill. One would think that the bill takes effect in 2014, so the taxes would take effect in 2014 as well, that everything will come together and start in 2014. That is what one would think, but they would be wrong. That is not the case. In fact, the biggest part of the taxes in this bill will take effect next month, less than 1 month from now. The taxes that are going to increase the cost of health care premiums, prescription drugs, equipment that you would use for medical care—the taxes start next month. The bill imposes taxes for 4 years before any person would be able to sign up for any of the plans that are going to be available, presumably, under this bill.

Let's walk through this: $22 billion in taxes on prescription drug manufacturers would start next month; $19 billion in taxes on medical device manufacturers, next month; $60 billion in taxes on insurance companies across the board, next month. What is going to happen? Of course, the cost of all of those items will go up. Americans will start next month paying more in insurance premiums. Americans will pay more for their prescription drugs and more for their medical devices because those taxes start next month for supposed programs that are going to start in 2014. Well, maybe you would think the benefits would start coming in 2011, 2012, 2013. Not at all. Nothing starts in benefits or programs until 2014.

But there are more taxes that come before 2014. In 2013, taxes on high-benefit plans take effect: $149 billion. This will affect union members, surely people making under $200,000. They will be affected starting in 2013, but any benefits from this bill would take effect a whole year later.

The limit on itemized deductions for medical expenses is also changed. Under this bill, you would have to spend 10 percent of your income on medical expenses before you could take a deduction. This is for people who have a terrible accident or a debilitating high-cost disease, such as a cancer treatment, maybe a clinical trial. So present law is 7.5 percent of your income, and you can start deducting these expenses. But with the new bill, starting in 2013, you have to go to the 10-percent threshold before you can have those deductions. So that would be another $15 billion in taxes to individuals.

Finally, in 2014, after 4 years of taxes and increases in premiums and medical devices and prescription drugs, then you would start seeing the rest of the bill take effect. In 2014, you still have more taxes. Mr. President, $28 billion in employer taxes will start in 2014. These are for employers who cannot afford to meet the threshold of what they will have to cover for their employees. Or individuals who cannot afford health care will have $8 billion in taxes. That starts in 2014.

I am working with Senator THUNE. There will be a Hutchison-Thune motion to commit this bill that will say the taxes start when the implementation of the bill starts. I think that is a matter of fairness. We want to commit the bill and say: Everything should start at once. How can we tax people for 4 years, raise their prices on insurance premiums, raise their prices on drugs, raise their prices on medical devices when they get none of the opportunities that would be in this bill until 2014?

I am going to be working with Senator THUNE, Senator GRASSLEY, and Senator HATCH to try to make the corrections in this bill that will present transparency and fairness to the public about what these taxes are and when they start, then, when the implementation of the program starts.

It is so important we have the ability to say to the American people, if this bill passes: You are not going to be taxed, your prices are not going to go up, your premiums are not going to go up—any more than they already have, caused by the increased taxes in this bill—at least until the bill is implemented. We are going to try to do that in the bill for the American people very soon. I am very much looking forward to talking about this issue.

I talked to someone last night who heard us starting to talk about the taxes in this bill, and they were astounded.

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

Mrs. HUTCHISON. They were astounded.

We are going to try to give relief to the American people and have a bill that will truly not have the taxes and mandates that are there now that start 4 years before the bill is implemented.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

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

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I thank the Presiding Officer and the chairman of the committee.

Mr. President, I rise today to speak concerning an amendment on which I am proud to join the Senator from North Dakota, Mr. BYRON DORGAN, and other colleagues in an effort to lower the cost of prescription drugs. But I do want to make one comment on Medicare before I do that.

We know our plan, overall, is about saving lives, saving money, and saving Medicare. That is what this is about overall. That is what we are doing in our health care reform proposal for American families. But I do want to mention and stress again this is about saving Medicare. It is about strengthening Medicare and our commitment.

I do have to say, we have been hearing from colleagues, and the distinguished Republican leader has said over and over again that, in fact, cutting Medicare is not what Americans want. Then last night he said here on the floor that expanding Medicare was a plan for financial ruin. So they do not want to cut, they do not want to expand. I am not sure where our colleagues on the other side are in terms of Medicare. But I know where we are. I know we are the party that created Medicare, with President Johnson at the time. We are the party that has continued to promote and to expand and to strengthen Medicare. We are the party that intends to make sure we save Medicare for the future, expanding prescription drug coverage, to be able to close the doughnut hole, to be able to expand the ability of seniors to have preventive care, and to extend the life of the Medicare trust fund, which is critically important.

And to that, I want to speak now to the other two provisions we have as our priorities: saving lives and saving money. The Dorgan-and-others amendment, which I am proud to join Senator DORGAN on, does exactly that. It will save lives and save money. As a Senator from Michigan, I know that very well. We can look across the Detroit River into Windsor and know that the people of Michigan, by going across the bridge, would be able to drop their costs 30, 40, 50 percent.

There is something wrong with the system where Americans are paying so much more than those in other countries for the same drug. The safety provisions are the same. The difference is there have been protections put up at the American border to stop Americans from getting the benefit of having our hospitals, our pharmacies, our schools of medicine, and others who use prescription drugs to be able to bring that back, to do business across the border.

Everybody is always talking about open borders, open trade. Well, this is a trade issue about bringing back FDA-approved prescription drugs across the border to the American side, so Americans have access to lower priced medicines.

It has been about 10 years now since I did my first bus trip to Canada with seniors. I have been doing that for a long time. I have been focused on this issue both in my days in the House of Representatives, where I took the lead on this issue, as well as now working with colleagues in the Senate. It is time to get this right in the context of health care reform because this is about saving lives and saving money.

I want to share one story. I have heard so many over the years from people in Michigan. But here is one recent story of someone who has written to me.

Joe is a 40-year-old father with heart disease. His family says despite his heart condition, he is doing well. He loves to work. His medicines cost over $4,800 a month. Can you imagine that? But his insurance has a family cap of $10,000 a year. In other words, after basically 2 months, he hits the cap, and he has to pay for everything out of pocket.

By going over the bridge to Canada—and we have three bridges: up in the Upper Peninsula, we have a bridge; in Port Huron we have a bridge; and in Detroit we have a bridge, the largest cross-border bridge in terms of volume of goods and services on the northern border—but by simply going across the bridge, Joe would be able to save $2,000 a month.

We should be able to do better for Joe and his family. He could save $2,000—almost half of his cost—by simply buying the same drug, FDA approved, from one side of the bridge instead of the other.

We also know that the cholesterol-lowering drug Lipitor is about 40 percent less, also the ulcer medication Prevacid is about 50 percent less, according to a search on Pharmacy Checker. I have to say that again. This is a trade issue and whether we are going to continue to have trade barriers. Because, for instance, Lipitor is made in Ireland and Pfizer is able to bring that back to America, they can bring it back. But if someone wants to go to Windsor, Canada, right across the bridge, and purchase a lower priced version of the very same drug, Lipitor, and bring it back as an individual or a business or a pharmacy or a hospital, it is illegal. It is illegal. That makes absolutely no sense.

This amendment is about opening the border, allowing our pharmacies, allowing our wholesalers, allowing hospitals—I have gotten calls from medical schools at universities wanting to do business, to lower their cost, with wholesalers in other countries where it is FDA approved, safe to do that. That is what this bill is about.

Right now, we are in a situation where if we do not pass the Pharmaceutical Market Access and Drug Safety Act, which we have introduced on a

bipartisan basis, we are going to continue to have a situation where people such as Joe, a 40-year-old father with heart disease, is going to be paying $4,800 a month out of his own pocket, when we could cut that down. It still would be tremendous, but we could cut that by $2,000 for him, by passing this legislation.

The drug importation bill is supported conceptually. We have been working over time with many different groups such as AARP, the Alliance for Retired Americans, Families USA, and Cato Institute—very different groups philosophically, but they all agree we need more competition, we need to open the border to safe—and I emphasize and underline ''safe''—FDA-approved prescription drugs so we are focused not on what is best for the pharmaceutical industry, the brand-name companies, but what is best for American citizens who are struggling, who see their prices go up 8 percent, 9 percent, 10 percent, 15 percent every year. Families cannot sustain that.

How many of us have stood on this floor and talked about the fact that people are choosing between food and medicine? That is not just rhetoric. It is not rhetoric. It is real. It is real for people right now today. It is getting cold. It is getting very cold. People are deciding: Am I going to keep the heat on or am I going to be able to get my medicine? Am I going to be able to get my food? Am I able to get my medicine? Am I able to pay the rent, the mortgage, or get the medicine I need for my life or for my child's life or for my husband's or wife's ability to continue to live a healthy, successful life?

That is what this is about. We have an easy, straightforward way to increase competition, to bring down prices, with safe, strong safety standards. This is something that makes sense. It will help seniors. It will help people with disabilities who are in the doughnut hole before we get that all closed under Medicare. It will help every family and every individual right now who needs medicine and is paying more and more, higher and higher prices every single year.

I hope we will have a very strong bipartisan vote. This is a very important addition to what we are doing here. This truly will save lives and save money; and that is what we are all about: creating competition to bring prices down so the American people have access to the medicine and to the health care they need and deserve.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, I want to speak briefly about keeping President Obama's promise to the American people when it comes to tax increases in this health care bill.

You will recall on September 12, 2008, he said:

> I can make a firm pledge: Under my plan, no family making less than $250,000 will see their taxes increase . . . not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.

The problem we see, though, is this bill, as proposed, increases taxes for 25 percent of taxpayers earning less than $200,000 a year. That is 42 million individuals and families who will be taxed in a way that violates President Obama's pledge.

According to the Congressional Budget Office, the Internal Revenue Service will need many more agents and workers in order to enforce the Reid bill. It will essentially need to double in size the Internal Revenue Service just to be able to raise those taxes called for in this big job-killing bill.

The possibility of higher taxes is one reason job creators are currently standing on the sidelines. The President had a job summit. Yesterday he spoke at Brookings Institute and talked about initiatives he was going to undertake in order to help create jobs in this country. But the fact is, government doesn't create jobs except to the extent we grow the size of government. What we need to do in this country is to get out of the way, reduce the burden, and limit the uncertainty for the private sector—small business that is the primary job-creating engine in this country.

But the fact is, job creators are nervous—I would strike that; they are not nervous, they are scared—about one job-killing proposal after another coming out of Washington. Not just the spending, not just the debt, but they see things such as this big health care bill and the increase in taxes that go along with it. Then they see the President going to Copenhagen and perhaps trying to obligate our country to some additional financial burdens that are going to make it harder for these job-creators, not easier.

The debt, for example, is one looming disaster. The total public debt now stands at $12 trillion. Before the end of the month, the majority leader is going to come to the Senate floor, presumably on a Defense appropriations bill or some other vehicle, and ask us to lift the debt limit because Congress has maxed out the American people's credit card, and we can't keep running the government unless we increase the debt limit.

Well, a number of us are not going to vote for that increase in debt limit until we receive firm assurances that the administration and the majority are going to get real about this increasing debt and unfunded Federal liabilities in Medicare, in Medicaid, and other entitlement programs.

We are accumulating debt even faster during this fiscal year. For example, in just 2 months—2 months of this year—the Congressional Budget Office says an additional $292 billion in deficits were accumulated. Our deficits will average nearly $1 trillion for every year during the next decade, according to the Obama administration itself. Of course, I mentioned the other unfunded liabilities out there—things such as Medicare.

I understand the majority has somehow cut a tentative deal to try to grow Medicare. Well, if you grow Medicare and grow Medicaid, what does that do to the already $38 trillion in unfunded liabilities? This $38 trillion is three times our national debt. It means, in essence, a debt burden of $32,000 for every U.S. family. Yet my colleagues don't seem desirous of fixing this problem. They seem determined to make it worse.

Yesterday the Washington Post reported on our Nation's deteriorating fiscal situation. They said:

> The problem is that, if investors think the United States isn't fiscally responsible—

I wonder why they would conclude that? But they go on to say—

> they could start demanding much higher interest rates when they bid on Treasury securities.

That is, when they start buying our debt, as a result of all of this spending and the money we have to borrow from China and other countries that buy our debt, those countries could begin to demand higher interest rates.

The Washington Post goes on to say:

> The feedback loop could get ugly. The Nation could have to borrow hundreds of billions of dollars just to pay interest on what it owes. This has been touted as a classic path to irreversible national decline.

The Post cited Leonard Burman, an economist at Syracuse University, who said:

> Right now, this year, we have $1.6 trillion in debt coming due—

And that is before we pass this ill-conceived health care bill.

He said:

> That's roughly twice individual income tax revenue. Our only plausible strategy for paying that back is to borrow more money.

The Post also cited David M. Walker, a former Comptroller of the United States, who recently testified:

> Our total Federal financial hole is about $10 trillion more than the current estimated net worth of all Americans and the gap has been growing.

Then, adding insult to injury, yesterday Moody's Investors Service said its debt ratings on U.S. Treasury securities ''may test the Triple-A boundaries'' because the government's fiscal status is worsening.

Well, the fact is, this Reid health care bill makes this much worse. My colleagues say the CBO—the Congressional Budget Office—has scored the bill as deficit-neutral. Well, any bill can be called deficit-neutral if you are willing to raise taxes enough and cut programs such as Medicare, both of which this bill does.

The Congressional Budget Office said in their score of the Reid bill:

> The long-term budgetary impact could be quite different if key provisions of the bill were ultimately changed or not fully implemented.

Well, what could they mean by that? What they mean is some of the assumptions about the cuts and other things that range over a 10-year budget window, if they don't come true, then all bets are off.

We know the Reid bill relies on budget gimmicks to hide the true cost of this Washington takeover. One gimmick is, for example, not including the Medicare provider fix, the so-called doc fix, which costs $210 billion over 10 years. In other words, this bill leaves that out entirely. I know—I am confident because Congress has only failed to act to reverse those cuts on one occasion—that if we let this cut in provider payments to physicians be fully implemented—a 23-percent cut come January—then many Medicare beneficiaries, including the vastly expanded rolls that would be included under this deal we have read about in the paper, patients will not be able to find a doctor to see them because doctors will not be able to continue seeing patients with a 23-percent cut in the payments they are entitled to under Medicare.

The other issue is the time shift. This is really sort of the classic shell game. The Reid bill starts the tax increases and the Medicare cuts in 2010, but as we know, the expanded coverage doesn't start until 2014. Someone said that is like buying a house, closing on the sale of a house, and being told: Well, you can't move in for 4 years. You have to start paying the bill today, but you don't get the benefits for 4 years.

The Congressional Budget Office score focuses on the budgetary impact to the government, not on the total cost to the American people. The CBO said the Reid bill increases the Federal budgetary commitments to health care. In other words, rather than trying to bend the cost curve as we have heard should be the goal, this makes it worse. We end up bending the cost curve in the wrong direction. The Reid bill will increase premiums for American families purchasing insurance in the individual market. The Congressional Budget Office hasn't yet been given time to estimate the total cost on the economy as a whole.

David Broder, one of the deans of the Washington Press Corps, did a nice roundup of nonpartisan experts last week. He cited Robert Bixby of the Concord Coalition, Maya MacGuineas of the Committee for a Responsible Federal Budget, and he concluded this:

Every expert I have talked to says that these bills as they stand are budget-busters.

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

Mr. CORNYN. So I hope my colleagues will pass the Crapo motion to commit this bill to the Finance Committee so the President can keep his commitment not to raise taxes on the American people.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Ms. KLOBUCHAR. Mr. President, I wish to speak in support of the Dorgan-Snowe importation amendment No. 2793, which provides some much-needed relief to Americans who are being crushed by ever-higher prescription drug costs. I wish to first note I am eagerly awaiting the details of some of the proposals that were put out there last night. I appreciate the work of my colleagues, but I do want to hear the response from the Congressional Budget Office. As I have said on this floor many times, I am concerned about expanding Medicare unless we do something about the geographic disparities that are already present in our system. When we look at some of the numbers, the average patient got $6,600 in Minnesota in 2006, and Texas is something like $9,300. What we want to try to do with this bill, and what I like about this bill, is all of the cost reform measures that are going to push us toward rewarding States that are participating in systems that provide more efficient care. If we don't do something about these geographic disparities, we are going to further exacerbate this by expanding Medicare.

So I have some concerns about this, and I look forward to hearing from my colleagues as well as, of course, the solvency of the Medicare Program, which is scheduled to go in the red by 2017 under existing circumstances.

Back to the Dorgan-Snowe amendment. This amendment not only would allow American pharmacies and drug wholesalers to import FDA-approved medications from Canada and several other countries and pass the savings on to consumers, it would also import some much-needed competition into the American pharmaceutical market. It is estimated that the amendment, which enjoys both Democratic and Republican sponsors, would result in Federal savings of $19.4 billion over 10 years, just at a time when we are looking for these kinds of savings.

Millions of Americans depend on prescription drugs to help them manage chronic disease or other illnesses, but drug prices continue to skyrocket with annual increases well above the general inflation rate. From 1997 to 2007, retail drug prices increased an average of 6.9 percent per year, more than 2½ times the general rate of inflation, which was 2.6 percent per year over the same period.

Look at that difference: 6.9 percent per year compared to 2.6 percent per year. As a result of these rising prices, many patients are forced to split pills, skip doses, or not fill their prescriptions at all. Yet right across the northern border of Minnesota and Canada, many of these same brand-name prescription drugs are available at a much lower cost.

For example, according to one recent comparison, a 90-day supply of Lipitor costs $256 in the United States. In Canada, it is available for $188. In other words, Canadians pay 26 percent less than Americans for the very same drug.

Here is another example: A 90-day supply of Nitroderm patches cost $303 in the United States but $125 in Canada. The Canadian price is 59 percent cheaper. We can go right down the line of major brand-name drugs and see these dramatic price disparities. In fact, every year, Canada's pharmaceutical pricing board compares Canadian prices for patented drug products with prices in a number of other countries. Consistently, prices in the United States are higher by double-digit percentages. In 2008 U.S. prices were, on the average, 63 percent higher than Canadian prices.

Now, current Federal law says no one except the manufacturer can import a drug into the United States. Wholesale and retail pharmacies aren't allowed to. State and local governments aren't allowed to. Individual Americans aren't allowed to, even for personal use. But, of course, they do, and they have been doing it for a number of years.

My State, as I noted, happens to be on the border of Canada. Every day Canadians cross over to Minnesota to work and make purchases and fish and do all kinds of things. Likewise, Minnesotans cross over to Canada every day to work and make purchases and fish. It is no big deal. We are not afraid of Canadians. Minnesotans know that Canadians pay less—much less—for many of their prescription drugs.

Beginning in the 1990s, the Minnesota Senior Federation started organizing bus trips for seniors to go up and cross the border into Canada so they could get affordable prices for the drugs they depend on.

The Senior Federation also introduced a prescription drug importation program and used its buying power to negotiate directly with Canadian mail order pharmacies to provide lower cost prescription drugs to Minnesota seniors. But drug prices in the United States just continue to go higher and higher and higher so the pressure to find some relief kept growing.

Finally, some State governments decided to take their own initiative to help their residents purchase lower cost drugs from Canada. Minnesota was one of the very first. There was broad bipartisan support for this with a Republican Governor and Democrats and Republicans in the legislature.

In February 2004, the State of Minnesota established RX-Connect, the first State-run Web site to provide citizens with information on how to safely purchase drugs from Canada. The Web site lists prices for hundreds of brand-name and generic medications as well as voicemail and e-mail contact information.

The American pharmaceutical industry likes to use scare tactics to keep people from buying their medications in Canada. Look at what is happening. You don't see a lot of problems there with their drugs.

The Dorgan-Snowe amendment takes on renewed importance and urgency because the American pharmaceutical industry has been imposing suspicious drug price increases this year. Last month, the New York Times reported that drugmakers have been busy raising prices for the most common prescribed medicines in anticipation of

possible health care reform. The newspaper quoted industry analysts as saying that in the 12 months ending September 30, drugmakers have raised the wholesale prices of brand-name prescription drugs by about 9 percent. Overall, that means an additional $10 billion in health care spending. That is the largest increase since 1992, and it happened even as the consumer price index declined during the same 12-month period. Some analysts suggest that these prices are being inflated artificially in expectation of new reform that could otherwise reduce prescription drug prices. A similar trend was observed just before Medicare Part D took effect.

Just last week, an economist at the University of Minnesota said:

> Curiously, prescription drug prices appear to rise more rapidly in periods just prior to major policy changes. Brand-name and specialty drug prices accelerated before the Medicare Part D program was enacted and implemented.

That is what we are talking about here.

This amendment would allow U.S. licensed pharmacies and drug wholesalers to import FDA-approved medications from Canada, Europe, Australia, New Zealand, and Japan and then pass on the savings to consumers.

Real health care reform requires real changes from business as usual. This amendment would start to bring some real changes—opening up new choices to American consumers and injecting new competition into the pharmaceutical marketplace.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. VITTER. Mr. President, I rise in strong support of the Dorgan reimportation amendment of which I am a cosponsor. I am very glad to support this important amendment. It is a bipartisan effort.

Unfortunately, most of this debate and effort about the underlying bill is anything but bipartisan. This is a welcome contrast to that, a bipartisan effort around a very important reform proposal—reimportation of prescription drugs.

We face an interesting situation. The United States is, by far, the biggest market for prescription drugs in the world. Yet with all that buying power and all that activity, we pay, by far, the highest prices in the world.

It is for a simple reason: We don't have a true worldwide free market in prescription drugs. We need to do that, in part, through reimportation.

Americans need lower prices. They need the sorts of prices being offered elsewhere. We need to break down this system by which the big drug companies can and do offer the same drugs at very different prices in different countries, and, of course, they offer them at the highest prices in the world in the United States. Americans should not have to choose between their lifesaving medicines and other basic needs, such as food and utility bills.

By voting for the Dorgan amendment and enacting comprehensive reimportation, we can directly address access to health care and truly lower health care costs, which I believe should be our top goal in this entire debate. That is what this amendment does. It gives Americans immediate relief from outrageously high prescription drug prices.

Our amendment allows individuals the freedom to buy their prescription drugs at affordable prices, while providing oversight to ensure that only FDA-approved and safe drugs are permitted.

Our amendment closes loopholes that big pharma has been using to fight reimportation, such as shutting down drugs to wholesalers who participate in reimportation.

Our amendment would close the poison-pill loophole requiring HHS certification, which has left it up to administrations to deny reimportation by making that comprehensive reimportation discretionary. It would shut down that poison-pill loophole.

We would make it mandatory that Americans have affordable choices for prescription drugs.

Many of us, Democrats and Republicans, and certainly including and starting with Senators DORGAN and SNOWE, have long fought for this comprehensive solution. We have made important steps forward. The Senate has adopted amendments to allow personal reimportation. Just last year, we voted overwhelmingly, 73 to 23, that we need to enact this sort of comprehensive reimportation reform, and we have taken concrete steps, such as the personal reimportation provisions, some of which I have authored and passed through the Senate. But we need to go further, and we need this comprehensive approach.

Obviously, the big stumbling block in the way is the powerful pharmaceutical lobby, big pharma, which has spent millions in lobbying to stop this comprehensive approach. Just this past summer, Senator MCCAIN read an e-mail on the Senate floor from a big pharma lobbyist outlining their strategy to derail those efforts in the Senate. More recently, there are reports that they may have struck a deal with the White House to derail these sorts of efforts and offered to spend tens of millions in support of so-called health care reform, perhaps with a deal to derail these efforts.

That is why I am so glad Democrats and Republicans are coming together around this amendment to say that enough is enough. We need to fight all of these backroom deals. We need to fight this pervasive influence by pharma and finally stand with average Americans and pass real, comprehensive reimportation reform that will bring down prices, bring down health care costs, which should be the top priority of all of us.

We all say we want to lower health care costs. That has been a big issue in this overall debate. Well, this amendment will absolutely do that. The Congressional Budget Office says that and independent analyses say that. Let's take an important step and do what we all say should be a top priority—actually lowering, in real terms, health care costs.

Again, I urge all of my colleagues, Democrats and Republicans, to come together in a bipartisan way. I wish more of this debate and this effort was designed from the beginning to be truly bipartisan. But this amendment and this effort is. This amendment and this effort have been discussed for years. Let's finally get it done with a bipartisan vote to pass comprehensive reimportation.

With that, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. BAUCUS. Mr. President, I ask unanimous consent that we extend the period for debate only until 2 p.m., with the time equally divided, with Senators permitted to speak therein for up to 10 minutes each, with no amendments in order during that time.

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

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, the Senator from Texas and others talked about premiums. I wish to discuss the effect on premiums of health care reform.

Affordability is at the crux of this debate. In fact, reducing costs and making health care premiums more affordable and predictable, while improving quality, is the impetus for this bill. This bill cuts cost and improves quality.

Two analyses have been released that show Americans will pay less and have more choices under this bill. The first is by the CBO. It found that the legislation will lower premiums for millions of Americans. According to the CBO—and there are a lot of claims around here to the contrary, but they are just claims, and it is not documented—according to the CBO, in the individual market health insurance premiums under the Senate plan would fall by 14 to 20 percent compared with the same plan under current law. If you compare apples with apples, premiums under the Senate plan will fall in the individual market by 14 to 20 percent. These savings come from lower administrative costs, from increased competition, and better pooling of risk to include healthier people. Again, in the individual market, premiums will fall 14 to 20 percent.

Let me be clear. CBO does say that those buying health care in the individual market will pay 14 to 20 percent

less under this bill than they would for the same plan under current law. If you currently have coverage you like, you can keep it. You will pay 14 to 20 percent less for that coverage than you would pay under current law. If, on the other hand, people in the individual market are unhappy with their coverage, what can they do? They can choose to purchase the more comprehensive coverage available in the exchange. You can keep what you have, but if you don't like it, you can choose to buy something else in the exchange.

Unlike most of the coverage available in the individual market today, the coverage in the exchange will ensure access to preventive benefits. This is a very important point. Unlike most of the insurance available today in the individual market, that is, people buying just for themselves, the quality of insurance they will get, because of very dramatic insurance market reforms, will be much greater than what they have today. The quality will be much better.

What are some of those quality improvements? First of all, the bill will ensure that insurance companies cannot deny coverage based on preexisting conditions. Moreover, people will have access to preventive benefits. The plan—the bill we are debating—will guarantee that every policy has an out-of-pocket limit. That is not true today. Most plans don't have limits on that. This legislation says you have a limit on out-of-pocket coverage. Insurance companies have to provide the insurance. They cannot provide a policy that says: We can only pay so much.

The legislation will eliminate discrimination by insurance companies against those who have been sick in the past or have a preexisting condition. They cannot deny coverage based on health status. They cannot do that anymore. They do that today.

This health legislation will preclude insurance companies from rescinding your policy if you get sick.

How many times have we heard that happen under current law, insurance companies rescinding a policy when you get sick because they find a little something that has nothing to do with your illness that you perhaps did not report, a preexisting condition someplace else.

For small businesses, the Congressional Budget Office estimates that premiums in the small group market could be 2 percent lower than under current law. For workers in small firms that are eligible for the small business tax credits, premiums would be 8 to 11 percent lower than under current law. Those savings alone make this legislation worthwhile for small business.

Another enormous benefit for small businesses under this bill is predictable premiums. Under current law, if you are a small employer and one of your employees gets sick, your premiums could double, triple next year. I have experienced that many times. I am sure most Senators have. They talk to small businessmen at home and a businessman says: My gosh, my insurance premiums have doubled, tripled, quadrupled over the past year. Why? Because one of my employees has a preexisting condition, and I am placed in this terrible dilemma. This is a key employee. I cannot fire that person to get lower premiums. I cannot pay the increase in premiums. What do I do?

There is one contractor at home in Montana I talked to about this. He felt so bad, he could not let somebody go, one of his best employees. He kept that employee. He kept shopping around, shopping around, and found a carrier that did increase his premiums because this employee had a preexisting condition but not as much as his regular carrier. It was a 20-percent increase rather than a 30-percent increase. That happens today, and it is wrong, wrong, wrong, wrong.

So if you are a small businessperson, under this bill, you are going to find your premiums are going to be much more stable, and there is going to be a greater pool of people so your premiums, the Congressional Budget Office said, will be less—not by a lot but a little less. You don't have to worry about the insurance company coming to you next year and saying: We are going to charge you much more.

Under this legislation, insurance companies can no longer discriminate against small employers that have an employee who gets sick. I mention all the time I hear from small businesses that say they want to buy health insurance for their employees, but it is too expensive and the cost is too unpredictable. They cannot do it. They want to. They cannot afford it. This legislation helps solve that problem. This bill creates a requirement that allows small businesses to provide health coverage to their workers. There is a little reduction in premiums, according to CBO, and also much more predictability and higher quality of insurance all at the same time.

In the large group market—that is companies with more than 50 employees—what does CBO say about their premiums? I have heard all these allegations about people who work for larger companies are going to find their premiums will increase. That is the assertion. That is flatly not true, at least not true according to the Congressional Budget Office. The Congressional Budget Office estimates that premiums could be up to 3 percent lower than under current law. Again, that is not a big reduction, but it is a reduction, nonetheless. CBO says employees who work for larger companies will find their premiums will go down by a little bit. The assertion is, premiums will go up. CBO says they will go down, to be honest, not by a huge amount but down a little bit. That is better, lower premiums. That 3 percent could make the difference whether an employer decides to keep employees. A 3-percent reduction in premiums will keep that employee, or a bunch of employees, working for him.

According to the Congressional Budget Office, five out of six Americans get their coverage through employers of this size. Five out of six Americans work for larger companies. This means 83 percent of Americans will see no change or perhaps a slight decrease in their premiums. That is the Congressional Budget Office. That is what they say. It is in black-and-white print. It is right there. The remaining individuals—that is 17 percent—purchase their coverage on their own in the individual market.

Of those, many will choose to retain the coverage they have and will see a reduction of 14 to 20 percent in their premiums. Those who choose to purchase more comprehensive coverage in the individual market, the vast majority—nearly 60 percent—will see a reduction in premiums. Guess what. That is a big reduction in premiums. They will see a decrease of 56 to 59 percent due to the tax credits provided in this bill.

Let me restate that point. For the majority of those who choose to buy insurance in the exchange, in the individual market, a majority will see a reduction in premiums, according to the Congressional Budget Office, a whopping reduction of between 56 and 59 percent due to the tax credits provided in this bill. That is pretty important. The remaining few individuals may see an increase of up to 13 percent. But those who experience an increase in premiums, let's remember, will do so because they have much better insurance. The increased quality of the insurance they are going to get, in my judgment, is going to outweigh the increase in premiums they have to pay because they are going to get a lot more for the buck, a lot better insurance than they otherwise would get today.

If you buy a new car rather than a used car, most people think maybe they will pay more for a new car as opposed to a used car because it is newer and better. That is what is happening today. You might pay more, but you are getting a lot better insurance.

The Congressional Budget Office analysis, therefore, is good news for health care reform. The analysis does not take into account some of the Senate bill's other policies, such as a catastrophic option available to young adults, otherwise known as ''young invincibles.'' They think: I am not going to get sick, so I will get a catastrophic plan and pay very low premiums. That is available in this legislation.

The Congressional Budget Office analysis does not incorporate the potential effect of the proposal on the level or growth rate of spending for health care. In other words, CBO's analysis does not fully capture the effects of the excise tax on high-cost plans, which will also help.

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

Mr. BAUCUS. I have more to say, too much more to ask for an additional minute. I will continue at a later time.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I rise to speak about Senator CRAPO's motion to commit the bill to the Committee on Finance in order that this bill does not increase taxes for individuals with incomes of less than $200,000 or families with incomes of less than $250,000.

Let's start by looking at three basic promises President Obama campaigned on to get elected—promises that almost no one on the other side of the aisle talks about anymore. Here are those promises. These are his quotes.

He says:

But let me [be] perfectly clear . . . if your family earns less than $250,000 a year, you will not see your taxes increased a single dime. I repeat: not a single dime.

Promise No. 2:

. . . nothing in this plan will require you or your employer to change the coverage or the doctor you have. Let me repeat this: nothing in our plan requires you to change what you have.

His third promise:

Under the plan, if you like your current health insurance, nothing changes, except your costs will go down by as much as $2,500 per year.

I think these are three promises that should be the test when we are judging this health care bill. I certainly agree with President Obama on all three of these points. The nonpartisan Joint Committee on Taxation has recently confirmed that this bill, in no uncertain terms, is a middle-class tax nightmare. Even after you account for taxpayers who receive the tax credit, 24 percent of tax filers—so that is a quarter of all tax filers—who make under $200,000 will, on average, see their taxes go up. Only 8 percent of all taxpayers receive the premium tax credit, which, by the way, is a new entitlement program, not a tax cut, as Democrats claim.

This news should not be a surprise to anyone. We have known for a long time that the largest tax in the bill, the so-called Cadillac insurance plan tax, falls heavily on the middle class. Eighty-four percent—let me repeat this—84 percent of the people who pay the tax have incomes of less than $200,000 per year.

What is wrong with this bill? This bill contains nine—that is right, nine—new taxes that will affect every American. I wish to walk you through those brandnew taxes.

First, we have the 40-percent insurance plan tax. This is the biggest tax, and it is designed to make insurance companies and employers drop their premium insurance plans and leave people to buy cheaper plans. As a result, this tax violates promise No. 2 and promise No. 3 that the President made that I showed in my first chart. It also violates the first promise because 84 percent of the people paying this tax are in the middle class, according to the nonpartisan Joint Committee on Taxation.

The insurance tax, tax No. 2, is another tax that will raise the cost of everyone's insurance plans. According to the analysis from the nonpartisan Congressional Budget Office, which I will quote, these taxes ''would increase costs for the affected firms, which would be passed on to purchasers''—in other words, the employees—''and would ultimately raise insurance premiums by a corresponding amount.''

In addition to violating the first promise not to raise taxes on middle-class Americans, it also raises insurance premiums and violates the third promise. This is not a good start for the American people.

Tax No. 3, the employer tax. For businesses that are struggling to stay afloat and to not lay off employees, especially during these tough economic times, this tax will make it much harder and may result in further layoffs in our weakened economy.

I thought our goal was to create jobs and to strengthen our economy.

The drug tax—this is tax No. 4. This tax will increase pharmaceutical prices. In fact, my colleagues should not be surprised that drug companies are already increasing their prices ahead of this bill because they know they are going to be taxed.

Tax No. 5, the lab tax. If you need clinical laboratory tests, then here is another way the government is going to pick your pocket.

Tax No. 6, the medical device tax. If you need surgery, there is a new tax on medical devices, such as pacemakers and other lifesaving devices.

Tax No. 7, failure to buy insurance tax. If you do not buy insurance, as this bill mandates, then you must pay a penalty tax. Do not be fooled by the new bill as it changes the name from ''tax'' to ''penalty.'' It is still money out of your pocket. By the way, 75 percent of that tax is on people who make less than $200,000 a year—once again violating President Obama's first promise.

I also wish to note that unlike the protection we included in the committee's bill to waive interest on criminal and civil penalties on people who do not pay this tax, the current bill on the floor only stops criminal penalties and certain enforcement mechanisms. This bill still allows the IRS to go after people who do not buy insurance.

What is the maximum penalty allowed? For a civil penalty in this bill, $25,000 for not paying this tax. That is what Americans can be penalized if they just fundamentally do not agree with this tax. Some people, such as myself, do not believe it is constitutional that the Federal Government can require us to buy health insurance. If you believe strongly in the Constitution and you do not believe this is a constitutional provision, the IRS can come after you and require up to a $25,000 fine.

The next tax to talk about is the cosmetic surgery tax. Ironically, Democrats want to tax the most market-oriented aspect of medicine that has resulted in lower prices, safer procedures, and more consumer satisfaction by taxing cosmetic surgery procedures.

Tax No. 9, increased employee Medicare tax. Lastly, for the first time, some Americans will pay higher Medicare taxes and that money will finance an entirely new entitlement program.

According to the nonpartisan Joint Committee on Taxation, as I mentioned before, 84 percent of the people who pay the so-called Cadillac insurance plan tax are in the middle class.

Let's consider the whole taxpaying population of the United States. According, once again, to the nonpartisan Joint Committee on Taxation, 8 percent of the population, or slightly more than 13 million, will get benefits that the Democrats tout under this bill. That is about 8 percent of our population.

The other side is wrong to say that this bill delivers a broad tax cut to all Americans. It does this for only 8 percent, and only after shifting $½ billion worth of new taxes around to the rest of Americans. And what about the rest of Americans? They are either clear losers under this bill or come out roughly even by getting a tax credit to balance their tax hike. Even after you account for taxpayers who receive the tax credit, about one-quarter of all tax filers under $200,000 will, on average, see their taxes go up, not down.

About 157 million Americans who get health insurance from their employers will not be eligible for the tax credit. This does not take into account the higher premiums, medical devices, drugs, lab tests that the nonpartisan Joint Committee on Taxation says will be shifted to consumers. They did not break those tax impacts down by income level, so we can't tell you exactly where they fall. But since most Americans make less than $200,000 a year, common sense tells you that most of those taxes will be borne by Americans making under $200,000 a year.

Most of the nine brand new taxes in this legislation violate the President's promise that middle-class families will not have to pay more taxes. The purpose of the Crapo amendment is to inject honesty into the health care debate and to hold Congress to the promises that were made to the American people.

Before we vote on this, I want to remind my colleagues of a very similar vote we had last year. I had an amendment to the Budget Act that was passed 98 to 0 by this body. My amendment last year said: It shall not be in order in the Senate to consider any bill, resolution, amendment between Houses, motion——

The PRESIDING OFFICER (Mrs. HAGAN). The Senator has used his 10 minutes.

Mr. ENSIGN. Madam President, I ask unanimous consent for an additional 1 minute.

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

Mr. ENSIGN. It shall not be in order in the Senate to consider any bill, resolution, amendment between Houses, motion or conference report that includes a Federal tax increase which would have widespread applicability on middle-income taxpayers. That passed 98 to zero. That provision was adopted. Unfortunately, it was stripped later when the budget resolution went to conference.

Let me say in conclusion, despite the actions my colleagues on the other side of the aisle made toward following that policy of not raising taxes on middle-income families, we continue to see legislative proposals—and the bill before us is exactly one of those legislative proposals—that do just that. So I support Senator CRAPO's motion to commit this bill in order to remove these onerous tax burdens on the American people.

My argument is simple: Let's do what we said we would do and protect middle-income families from these taxes.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. CASEY. Madam President, I rise this morning—or this afternoon, I guess it is—to speak about health care, but in a very particular context—an area of our health care debate which we, unfortunately, haven't spent enough time on.

The purpose of my remarks today will focus on an amendment that I will be filing today that is entitled ''Support for Pregnant and Parenting Teens and Women.'' It is a challenge within our health care system which I think has gone largely unaddressed, or at least for a segment or a category of pregnant women in our society. We know many teens and women who face an unplanned pregnancy do so with little or no support. This amendment—the Pregnant and Parenting Teens and Women amendment—offers teens and young women the support they need to finish their education and provide for their children. This is especially important to those teenagers or women who are victims of domestic violence or other kinds of violence, and also women on college campuses.

Just a quick overview of the amendment, and then I will walk through some of the main reasons why I think it is important we make this a priority.

First of all, the amendment will provide assistance and support for pregnant and parenting college students. Secondly, the amendment will provide assistance and support for pregnant and parenting teens. Third, it will improve services for pregnant women who are, as I mentioned before, victims of domestic violence, sexual violence, and stalking. Fourth and finally, it will increase public awareness of the resources available to pregnant and parenting teens and women.

I will go through some of the background in the time I have, but the way I look at this—and I think the way a lot of families look at this challenge in America—is that often after a woman becomes pregnant, she has a decision to make. Under our law, she can carry the child to term or not. We want to make sure if she decides to carry that child to term she has all of the help she needs. And not just a little help—not just a program or two here and there—but the full range of help that we can provide, in addition to what so many people and so many organizations do so well.

There are many individuals and organizations in the nonprofit sector, and there are great programs out there right now that help women with their pregnancies, but I look upon this challenge as one that is faced by pregnant women of all incomes, of all backgrounds, and of all circumstances. Even a woman who has the resources and the means often feels that she has to walk that path alone. Sometimes her family abandons her or doesn't provide her the help she needs. But it is especially urgent and especially difficult when a woman is both pregnant and without means or is pregnant and poor, pregnant and vulnerable to all of the challenges she will face.

If a woman makes the decision to bring a child to term and to raise the child, she often does that all alone. What I believe we have to do here—not just as Democrats and Republicans, because that doesn't matter, candidly, on this—we have to do as Americans, if we mean what we all say, that we want to help people who are vulnerable, and we want to help people with their health care, and many of us say that over and over—people in both parties say that—then we have to help women during what can be a very difficult time in their lives.

I realize for some people this is not an issue. Pregnancy is a time of joy and a time when they have no challenges and they bring a child into the world with a lot of support and all the help they need. But there are plenty of women out there who have to walk this road all alone—all alone. And so if we mean what we say about helping, as Americans—forget parties here—we should do everything possible to walk that road with her, if she wants the help and if she can benefit from the services we are talking about.

Why should a woman on a college campus who makes a decision to have a baby be left alone? Why shouldn't we be giving her help? We don't do it now. I know some do it, and I will hear from others that this group does this and this group does that, but unfortunately it is not nearly enough, especially for someone who happens to be a teenager, a woman who is pregnant, or a young woman who is pregnant as a teenager or before the age of 18. Are we doing enough to help that woman who happens to be pregnant get through the challenge of a pregnancy?

Finally, and most horrifically, if a woman is both pregnant and the victim of domestic violence, sexual violence, or stalking, what are we doing to help her? Unfortunately, the answer to that is very little—very little. I think this is a criticism I am making of both political parties. We could have a debate about who is doing more, and that might be instructive, but neither party is doing enough for at least those three categories of pregnant women—teens, women on college campuses, and women who are victims of violence.

I believe we are going to have an awful lot of support for this amendment. I think it is an essential part of this health care debate, and I believe it is an opportunity to bring people together to agree on something around here when we have a lot of disagreement. But also I think it is vitally important to our society in general. It is not just a good thing to do, it is not just the right thing to do or the compassionate thing to do, it is, I believe, a very important part of how we deliver health care and how we help people through what is often a crisis.

Think of the kind of life that mother will have during her pregnancy and after her pregnancy. Think of the life that child will have, while the child is in the womb and then after the child is born. If the pregnancy goes well, the child will learn more. If the pregnancy goes well, the child will grow and develop appropriately so that he or she can be healthy. If a pregnancy goes well, the child will contribute a lot more to society. The real challenge, the urgent question for us is: What are we doing to help pregnant women, especially in these particular categories?

I have been so fortunate, and I am grateful to have worked with Senator KLOBUCHAR on this amendment. We will be talking about it more, but I wanted to provide a summary of it now.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. JOHANNS. Madam President, over the weeks and months we have been here, we have talked a lot about the economy and the challenges we face in the economy. We have spent time trying to figure out the best approach when it comes to job creation. We went through a debate earlier this year regarding a stimulus package that, when you add on interest, was eye popping—$1 trillion. We were promised by the President that if you pass this gargantuan stimulus package, the unemployment rate won't go over 8 percent. Well, we stand here today with unemployment at 10 percent.

We look at that and we recognize that the 10-percent number doesn't tell the true story of the suffering that is going on out there. When you read much farther in the analysis, you begin to realize it is not 10 percent. When you add in those who have flat given up, those who are underemployed, and those who may be piecing one or two or three jobs together to try to pay the bills, we are closer to the 17.5 percent range. And in spite of that, over the last days, we have been talking about a piece of legislation that, because of mandates and tax increases and burdens placed upon the middle class and our job creators—our small businesses—we can see very clearly we are going to end up with adding to the misery of the American people.

Let me, if I might, start out by focusing on a specific piece of this to get started; that is, the employer mandate.

The bill here and the bill in the House have a common element—certainly different mandates, certainly different amounts of the mandate, but the common element is that under both pieces of legislation there is a ''Washington way or the highway'' sort of approach. It basically says to employers: Thou shalt do it our way or there is the highway. It basically says to our job creators out there that our medium-size, even some of our small job creators are going to be pulled into this. It says: Look, you either do it the Washington way or we are going to penalize you. We are going to use the Internal Revenue Code, the full force and effect of this mammoth government bureaucracy called the Internal Revenue Service, to get you, to get that money out of your business because you have not complied with the Washington way of this legislation. We are going to put a tax on job creators, a penalty on job creators who are already facing the dilemma of how do they keep their employment steady at a time when unemployment is 10 percent and real unemployment is actually in the vicinity of 17.5 percent. The result is obvious. You don't have to study this very long to figure out that if this bill is passed, you are hammering the very people who are supposed to be creating the jobs.

According to our Congressional Research Service:

> Economic theory suggests the penalty [and by that they mean the employer mandate] should ultimately be passed through to lower wages . . . if firms cannot pass on the costs in lower wages, the higher cost of workers may lead firms to reduce output and the number of workers.

Let me kind of pierce through that fancy language, if I might. It kind of sounds like Washington-speak to me. What the Congressional Research Service is saying is this: If you are a worker out there in the United States, you are literally going to be faced with lower wages. If that doesn't work, then it may be your job that is at stake.

Like every Senator in this body, I get across my State. I try to listen to people. I have townhall meetings. We try to keep an open-door policy so if somebody wants to talk to me, they can. The human misery of losing a job is just unbelievable. It does something to a person. It makes them look at themselves very differently. It makes them wonder, is there hope out there?

This administration ran on this notion of hope and promise. According to our Congressional Research Service, when you pierce through that Washington-speak language, what it really says is that this bill by this administration is going to create more human misery because it will impact jobs. Nonpartisan analysis says employer mandates will either decrease wages or lead to layoffs.

This is my first year in the Senate. What a legacy for your first year, that you get to go home at some point and you say: You know, I voted for a bill that, according to the Congressional Research Service, will either cause more layoffs in my State or reduce wages.

Employers will look at their balance sheet—they have to. They don't have the ridiculous opportunity we have here of just spending crazily and running up the Federal deficit. They have to make it work or they go out of business. For them, it has to be a cost-benefit analysis. How many have looked at this bill and said: I think I have figured something out here. I don't like the mandate, they tell me. But then they say: But we have studied this, and if there has to be that result, it is cheaper for us to try to figure out a way to drop our health coverage and pay the penalty. The average employer that provides a health care plan pays about $4,000 per employee for health coverage. If the mandate were something like $750—do the math—a cost-benefit analysis is going to lead to one conclusion: Drop the health plan. We know employers are already considering it. My office recently met with a human resources manager from one of Nebraska's largest cities. She noted how much cheaper it would be if they could just do that. Many employees will lose their coverage. If that happens, then all of a sudden the doctor-patient relationship is impacted.

Remember all those promises: Your taxes are not going to go up; you get to keep the doctor you like; if you like your plan, you are not going to lose it. We have ripped those promises up with this legislation. You would think at some point somebody in the administration would stand up and say: Hold everything here, we are making shambles out of what we thought we could do.

True health care reform should lower costs for businesses so they have more capital to work with, so they can hire workers, not dismiss them. I suggest this bill just completely misses the mark.

I also suggest that this is a step in the wrong direction in terms of health care. Making matters worse, the people this bill supposedly helps will be disproportionately impacted. A professor studying employer mandates recently said this:

> Workers who would lose their jobs are disproportionately likely to be high school dropouts, minorities and females. Among the uninsured, those with the least education face the highest risk of losing their jobs under employer mandates.

Is it a surprise that business groups are opposing this legislation? The U.S. Chamber, Wholesale Distributors, General Contractors, Independent Electrical Contractors—all sent a letter recently, and they said this:

> Perhaps no sector has been more passionate, more active than the small business community in working to advance reforms that lower health coverage costs.

The PRESIDING OFFICER. The Senator has used 10 minutes.

Mr. JOHANNS. May I have an additional minute, by unanimous consent?

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

Mr. JOHANNS. The Senate health care bill '' . . . will lead to higher costs and increased burdens on small businesses. The bill will cause greater damage to our economy and health care system.''

We all agree on some basic premises. One is that about 60 to 70 percent of our jobs in this country are dependent upon small businesses. Isn't this a time for us to take a step back and ask what are we doing to our economy here, what are we doing to these job creators, and work together to get a truly bipartisan bill that builds our economy and protects our jobs?

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. It is alleged here on the floor that the underlying bill raises taxes. The legislation does not increase taxes—essentially. There was a slight modification to that, but I will explain that later. In fact, the bill represents a tax cut. The bill does two things: It provides tax credits to low- and middle-income individuals and families to help purchase health insurance and it results in increased wages for those receiving employer-sponsored insurance.

Let me first speak about how the bill provides a tax cut. The chart behind me basically shows that for a family of four with an income of $66,000, the light blue indicates that the cost of that health insurance is going to be about $14,100. That is basically what health insurance costs today for a family of four. That is what people pay today. After this legislation, look at the bar there on the right. Again, a family of four, income $66,000. Those persons will receive an $8,000 tax cut, in terms of credits that family will get, with a net result of a health insurance policy that costs $6,100. Health insurance is going to cost less for a family of four with an income of $66,000. That is fairly representative, a family of four with $66,000.

Just to repeat, on the left, the health insurance policy for a family of four with that income level is about $14,000. After the tax credit kicks in, once this legislation kicks in, the same family, same four people, will find they are paying only $6,100 net for their health insurance. Why? Because they get a tax cut of $8,000.

I might add—look at the next chart, ''Who Gets A Tax Cut? An individual with an income of $32,000.'' Earlier, it was a family of four with $66,000. This is an individual with an income of $32,400. Currently, today, before health care reform is passed, that individual will pay roughly $5,000 in health insurance. But after this bill is passed, that same individual with an income of $32,400 will find that health insurance will not cost $5,000 but much less—$3,000. Why? Because that person gets a tax cut in terms of a credit of $2,200. I think that is a very important point to make.

While we are at it, we might as well get the next chart.

There are some who are saying this legislation will result in increased taxes for higher income people; that is, people whose income is, say, around $200,000. There is something to that argument, but that is not the whole story. Let's look at the whole story.

This legislation as portrayed by this chart shows:

High-cost insurance excise tax leads to increased wages.

Why increased wages? Because the Congressional Budget Office or maybe it is the Joint Committee on Taxation—the Joint Committee on Taxation concludes that because of that provision of the bill; that is, the excise tax on companies that provide more expensive policies, in effect those policies will be modified or changed, and in effect the premiums for those policies, the so-called Cadillac plans, will actually go down, according to the Congressional Budget Office, between 7 and 12 percent. But that is premiums. The discussion right now is on taxes. Those folks will be paying a little more taxes. That is true under this legislation. But, again, what is the whole story? Why are they going to be paying more taxes? They are going to be paying more taxes because they will get more income. Their wages and salaries will increase tremendously.

Look at the bar on the left. In the year 2013, the percent of the total tax revenue due to increased wages will be about 90 percent, but that person will also pay a 10-percent increase in taxes. The wage increase, salary increase is far greater than the tax increase. That is true for every year—2013, 2014, 2015, all the way up to 2019. It is proportionately basically the same—roughly around an 80-percent increase in wages and roughly maybe about less than a 20-percent increase in taxes. So on a net basis, those persons are going to be doing pretty well.

Consider the example of Joe who works for ACME Company. He is married and has two children. Together, he and his spouse earn $100,000 a year in taxable wages.

In 2012, ACME Company provides family health coverage to Joe at a cost of $25,000. Because of the high cost insurance excise tax, ACME Company finds different coverage that costs only $21,000 in 2013. Thus, ACME Company can afford to pay Joe an extra $4,000 each year.

Now, even though Joe has to pay income and payroll taxes, he will still have an extra $2,076 in his pocket. That is $4,000 −$1,000 in Federal tax −$612 FICA tax −$312 in State tax.

I don't believe Joe would refuse a pay increase just because he has to pay taxes on that raise.

Or consider Sally, a single mother of two working for XYZ Company. She makes $50,000 in 2013 and receives family health insurance coverage costing $27,000.

When XYZ Company restructures their plan to $22,000 as a result of the high-cost insurance tax, Sally will get an extra $5,000 in wages. That is $3,095 in take-home pay after taxes. That is $5,000 −$750 in Federal income tax −$765 FICA tax −$390 State tax.

I have no doubt that Sally will be able to put that extra money to good use.

Also, I would like to remind everyone about this legislation on premiums. Earlier, I discussed what the Congressional Budget Office said about premiums under our bill. Let me repeat, this is what the Congressional Budget Office says: In summary, the Congressional Budget Office concludes that 93 percent of Americans receive decreases in premiums. About 93 percent of Americans net will see a decrease in premiums.

That is not from these charts; that is from the CBO letter. Of that 93 percent, 10 percent will see decreases of 56 percent to 59 percent because of new tax credits. We are talking about on the individual market. About 60 percent of those who are getting insurance in the individual market on the exchange will get tax credits which will result in roughly a 60-percent reduction in premiums. It is between 56 and 59, which is pretty close to 60 percent. The remaining 7 percent will pay slightly higher—100 less 93. Seven percent will pay slightly higher, but they also get much better insurance for that same dollar. When you have a choice between buying a used car or a new car, you probably expect to pay a little bit more when you buy the new car. Hopefully, it is a little better, higher quality, drives faster, safer, all those things. You expect to pay a little more for a new car, but you get more. The same thing here. You are going to pay a little more. But only 7 percent will see their premiums go up according to the CBO. Those 7 percent are people who do not get tax credits because their incomes are a little higher, but they will get much better insurance, higher quality insurance. CBO says that, much higher quality insurance.

So, in effect, they will probably get at least the same, maybe no increase at all, maybe a reduction in premium, if we calculate in the higher quality insurance they will have.

In addition to CBO, MIT's Jon Gruber has also done a study on premiums. And what does he conclude? He concludes, using Congressional Budget Office data, the Senate bill could mean people purchasing individual insurance would save every year $200 for single coverage and $500 for family coverage in 2009 dollars. Most people think he is one of the best outside experts. He has big computer models. He takes the CBO data and, in some respects, he has helped CBO by giving some information to CBO that it otherwise does not have.

Mr. Gruber also points out that people with low incomes would receive premium tax credits that will reduce the price they pay for health insurance by as much as $2,500 to $7,500.

We have also seen several studies funded by the insurance industry. I don't want to be disparaging but to some degree you have to consider the source. I have been citing CBO. I think most people think they are a highly professional outfit, no axe to grind. Sometimes they upset those against health insurance reform. Sometimes they upset those for health insurance reform. They are a very professional group of people. But I have also seen studies paid for by the private sector, by the insurance industry. Those studies find that premiums will increase under the bill before us for all Americans. These studies are flawed and, frankly, some of them, the authors of these studies admitted they are flawed. They were just looking at selective parts of the legislation, not all parts, and they were pushed by the industry to issue a report quickly. They have admitted that. Each of them failed to take into account all aspects of the proposal. They selectively chose the provisions that will increase premiums, and they ignored those provisions that will lower premiums.

Why do they do that? Basically, the insurance industry wants to kill this bill. I can understand it. If I were the insurance industry, I wouldn't want my apple cart upset either. They do just fine under the status quo, thank you very much. They don't want to see any changes. Some insurance companies want to continue their current practices of denying coverage if you have a preexisting condition. That is how they made their money in the past. They made most of their money by denying coverage, by underwriting insurance rather than making money on conventional insurance. Anyway these companies want to continue their current practice of denying you coverage if you have a preexisting condition. Some want to continue charging unaffordable premiums if you have been sick in the past, and some want to be able to rescind your coverage once you get sick. That is their MO, and they have done pretty well under the status quo.

The Congressional Budget Office and Professor Gruber are both credible and unbiased sources that are not bought and sold by the insurance industry. The Congressional Budget Office and MIT's Gruber have confirmed what many of us have known: that the bill before us will lower premiums and provide a great many options for more comprehensive coverage. That is very important. With the exchange set up and with other provisions that will be in this bill, there are many more options for individuals to buy insurance with. It creates a lot of competition. With health insurance market reform, insurance companies will be competing more on price than they are on quality of coverage.

This legislation provides much needed assistance as well to lower middle-income Americans struggling to pay their health insurance premiums.

The Senator from Nevada, Mr. ENSIGN, a few moments ago said people

would pay more because of industry fees in this bill. Let's address that point. The reductions in premiums determined by the CBO that I described earlier took into account any impact of the industry fees. The Congressional Budget Office took that into account. I note for the record, there is no lab fee. I know that was an honest mistake on his part, but I want to indicate there is no lab fees in this bill. He was talking about lab fees.

The bottom line is that for the overwhelming majority of Americans, this bill means lower premiums. I don't have it with me, but also a section in one of the CBO letters basically says these fees will have a very negligible impact on consumers. Frankly, I was a bit surprised. I was concerned that some of these studies might, as determined by the CBO or other outside analysts, conclude that there would be a significant impact on consumers and on premiums, basically, what these companies would otherwise charge. But the CBO says no; the fees on hospitals, the pharmaceutical industry, even the insurance industry will have a very negligible effect on increased costs for consumers. It is negligible according to the CBO. I thought, frankly, that would not be the case.

Here is the letter. It is on page 15. I don't have the date of this letter, but it is from the Congressional Budget Office. It is under the section ''New Fees Would Increase Premiums Slightly.'' The operable sentence is:

> Because that fee would not impose an additional cost for drugs sold on the private market, CBO and [Joint Tax] estimate that it would not result in measurably higher premiums for private coverage.

To be fair, I don't know if they also address the effect of hospital fees or other provider fees. But I think it is noteworthy in that context for us to remember, it wasn't too long ago when the health insurance industry got together at the White House with the President and promised the President they could reduce their costs by $2 trillion over 10 years. If they believed they could reduce their reimbursement by $2 trillion over 10 years, you would think they would kind of know what they are talking about. After all, they have to report to stockholders. They have certain obligations.

They said they could reduce their reimbursement by $2 trillion. This bill cuts down their reimbursement increases not by $2 trillion but by one-quarter of that. That is roughly 4,500 billion over that same 10-year period. They have agreed to that. I can understand why they would agree to that because that is about one-quarter of what they promised earlier.

If they have agreed to it, they are probably going to do OK under this legislation. It is not going to result in reduced quality of care to people because they have agreed to it essentially. As I pointed out, CBO says, at least with respect to the pharmaceutical industry, very little of that will be passed on to consumers. Why is that? The basic reason is, there is waste in our current health care system. These companies know where the waste is. They can find it. They know it is out there.

But, second, with increased coverage, many more Americans will have health insurance. Currently, 84 percent have health insurance. Under this legislation, 94, 95 percent of Americans will have health insurance. If many more Americans have health insurance, there are more patients for the hospitals, more patients for home health care, more medical equipment sold, more drugs provided by the pharmaceutical industry. That is the second main reason they know that with provisions in this bill, the reduction in reimbursement to them is numbers they can live with.

I know the next two speakers, Senator GRASSLEY and Senator DORGAN, both intend to speak for more than 10 minutes. I ask unanimous consent they be allowed to speak longer under the time under the control of the respective sides.

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

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I thank the Senator from Montana for arranging that for me. I hope this afternoon to speak on the issue of importation of drugs because I support the Dorgan amendment. Right now I wish to address the issue of the Crapo motion to commit.

This generally deals with all of the tax provisions in this 2,074-page bill. If Senator CRAPO prevails—and he should—the unrelated House bill, along with the Reid amendment, would be sent to the Senate Finance Committee. The Finance Committee, under the motion, would be empowered to return the bill to the full Senate with an amendment that eliminates the heavy taxes that are in this bill. Senator CRAPO has discussed the impact of the Reid amendment on middle-class families. I will lay out all the taxes that are in this bill.

In farm country, many of us who work the land often observe big freight trains rumbling across the terrain. Sometimes they scare cattle, hogs, and other animals. Those freight trains are impressive in their power, in their speed, and now the length of the trains. It is very common to see a 100-car train, 150-car trains. The partisan force with which the majority is powering this bill through the Congress is equally as impressive as that of a freight train. The speed that is being displayed for such complex legislation is something to behold. Most importantly, the sheer number and breadth of the new taxes in this bill reminds me of a very long train.

Almost $½ trillion in taxes, fees, and penalties, and I think they all have the same economic impact, whether it is a tax, a fee, or a penalty—a negative impact on the economy. These taxes, fees, and penalties are so imposing, I am calling this 2,074-page bill the tax increase express.

The locomotive driving this train is health care reform, driven by the Democratic leadership. So we have the locomotive that drives this tax increase. I don't think the American public knows the bill would impose that much, $½ trillion worth of new taxes, new fees, and new penalties on the American people.

The American public, who supported President Obama with a majority of votes 13 months ago, heard the President loudly and clearly, and that is why they gave him such an overwhelming majority.

They understood our President pledged he would not raise taxes on people making less than $250,000 a year. Unfortunately, the Democrats' leadership bill would violate that clear pledge.

What are the tax increases and the fees and penalties in Senator REID's amendment? Let me take a moment to highlight them because every locomotive needs power to run. The first power source, the first car of the tax increase express, is the so-called fees on health insurance companies, medical device manufacturers, and drug manufacturers.

That might not sound like something the grassroots of America would worry about—taxes on insurance companies, medical device manufacturers, drug manufacturers—because maybe they think businesses pay taxes. But businesses and corporations do not pay taxes, only people pay taxes. So when people find out they are going to be paying these, it puts a whole new light on what is a fee and what is a tax.

There have been numerous studies that have shown that these fees on, for example, health insurers will increase health insurance premiums. Some say premiums would increase by $488 for a family, other studies say $500. Most Members on the other side of the aisle take issue with these studies. They argue these studies were performed at the request of insurance companies or conducted by independent experts with ties to that same industry.

Let me ask my Democratic friends this: Do you question the work of the Congressional Budget Office and the Joint Committee on Taxation? Well, you should not because they are like a god around here. When the CBO says something is going to cost something, that stands, unless there are 60 votes to override it in the Senate. So most everything the CBO says stands. They have respect because of the intellectual honesty of their research and the nonpartisanship they have. So these agencies—the Congressional Budget Office and the Joint Committee on Taxation—have testified that these fees will actually be passed on to health care consumers. Check the record. No one can dispute it.

The Congressional Budget Office and the Joint Committee on Taxation have also testified that the fees will increase

health insurance premiums. Check the record. No one can dispute it.

My friends in the Democratic leadership may say, once their health reforms are in place, premiums will go down, net of the fees. They will hail a recent CBO report highlighting the winners but somehow ignoring the losers. They will say these fees will not affect premiums for the vast majority of Americans. But here is the flaw in that assertion. The Congressional Budget Office analyzed premium costs, what they are projected to be in 2016 under this legislation.

What about premium costs right now in the years before these programs take effect—2010 and 2013? Why is this question important? The answer is, these fees go into effect in the year 2010, not when most of the expenditures go into effect in 2014.

The majority of the Democratic reforms which are intended to lower costs do not go into effect until 2014—4 years from now. I ought to say that 10 times because that is very important to how this bill came out to be revenue neutral.

So we ought to look at what happens in the years 2010, 2011, 2012, and 2013. Premiums will go up. Why? Because, for one, the Democrats are adding costs to the health insurance you buy by imposing these fees on health insurers, and they are giving you no government assistance to help with these added costs.

I would ask my friends in the media, dig a little bit deeper on this point, and you ought to be reporting on it. Why? Because the American public does not understand that in the short term premiums will go up. Instead, the public is simply hearing some media reports on a portion of the premiums, in 2016 and beyond. Of course, that is a very long time from now. The American public does not want to wait for their premiums to go down, if they go down at all. It appears my friends in the Democratic leadership want the tax increase express to barrel through Congress before the public realizes what health care reform actually means; that is, higher premiums as early as 2010.

Let me turn to the second car of the tax increase express. This car is the proposal to restrict the eligibility criteria for claiming the itemized deductions for medical expenses. This proposal says you can no longer deduct expenses that exceed 7.5 percent of your adjusted gross income. Instead, you can only deduct expenses that exceed 10 percent of your adjusted gross income.

In plain English, this proposal limits tax deductions you can take for medical expenses. In other words, you will lose a portion of your tax deductions. Even the New York Times calls proposals that would take away a portion of your tax deduction a tax increase.

Mr. President, I ask unanimous consent that article from the New York Times, dated February 26, 2009, be printed in the RECORD.

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

[From the New York Times, Feb. 26, 2009]

TO PAY FOR HEALTH CARE, OBAMA LOOKS TO TAXES ON AFFLUENT

(By Jackie Calmes and Robert Pear)

WASHINGTON.—President Obama will propose further tax increases on the affluent to help pay for his promise to make health care more accessible and affordable, calling for stricter limits on the benefits of itemized deductions taken by the wealthiest households, administration officials said Wednesday.

The tax proposal, coming after recent years in which wealth has become more concentrated at the top of the income scale, introduces a politically volatile edge to the Congressional debate over Mr. Obama's domestic priorities.

The president will also propose, in the 10-year budget he is to release Thursday, to use revenues from the centerpiece of his environmental policy—a plan under which companies must buy permits to exceed pollution emission caps—to pay for an extension of a two-year tax credit that benefits low-wage and middle-income people.

The combined effect of the two revenue-raising proposals, on top of Mr. Obama's existing plan to roll back the Bush-era income tax reductions on households with income exceeding $250,000 a year, would be a pronounced move to redistribute wealth by reimposing a larger share of the tax burden on corporations and the most affluent taxpayers.

Administration officials said Mr. Obama would propose to reduce the value of itemized tax deductions for everyone in the top income tax bracket, 35 percent, and many of those in the 33 percent bracket—roughly speaking, starting at $250,000 in annual income for a married couple.

Under existing law, the tax benefit of itemizing deductions rises with a taxpayer's marginal tax bracket (the bracket that applies to the last dollar of income). For example, $10,000 in itemized deductions reduces tax liability by $3,500 for someone in the 35 percent bracket.

Mr. Obama would allow a saving of only $2,800—as if the person were in the 28 percent bracket.

The White House says it is unfair for high-income people to get a bigger tax break than middle-income people for claiming the same deductions or making the same charitable contributions.

The officials said the resulting increase in revenues, estimated at $318 billion over 10 years, would account for about half of a $634 billion ''reserve fund'' that Mr. Obama will set aside in his budget to address changes in the health care system. The other half would come from proposed cost savings in Medicare, Medicaid and other health programs.

In a document summarizing its proposals, the White House said it would finance coverage for the uninsured in part by ''rebalancing the tax code so that the wealthiest pay more.''

Mr. Obama's blueprint, which will project spending and revenues for the next decade, will flesh out the president's thinking on his energy plans both to cap the emissions of gases, particularly carbon dioxide, that are blamed for climate change and to spur development of nonpolluting energy alternatives.

The budget will show the government beginning by 2012 to collect billions of dollars in revenues from selling permits to businesses that emit the polluting gases, assuming the president's energy initiative becomes law as soon as this year, officials said.

Because utilities and other businesses would presumably pass on their costs to customers, Mr. Obama will propose to use most of the government's revenues from the permits to finance an extension of the new ''Making Work Pay'' tax credit beyond the two years covered in the $787 billion economic recovery plan that was just enacted.

That tax relief, the administration will argue, will offset households' higher costs for utilities and other products and services from businesses' passing on their permit expenses.

That tax credit annually will provide $400 to low-wage and middle-income workers or $800 to couples; Mr. Obama would like to increase those figures to $500 and $1,000. The credit phases out for those with incomes above $75,000 a year and for couples with incomes of more than $150,000; no benefit would go to individuals with more than $100,000 income and couples with $200,000.

The tax credit will begin showing up in the form of lower withholding for eligible workers beginning April 1.

The remainder of the projected revenues from the permits will finance Mr. Obama's campaign promise for $15 billion a year over 10 years to subsidize research and development of alternative energy sources, officials said. The stimulus package included a multi-billion-dollar down payment to develop a national electricity grid to harness and distribute energy from such sources, including wind farms.

Behind the numbers in Mr. Obama's first budget is one of the most far-reaching domestic agendas in years, and at a time when the president and Congress are already grappling with an economic crisis worse than any in decades. The environmental permits would not take effect until 2012, at which point the administration expects the economy to have recovered. Similarly, some of the tax increases would not take effect until 2011.

Democratic Congressional leaders promised to push the agenda, which parallels their own. ''By the end of this year, I want to do something significant dealing with health care,'' the Senate majority leader, Harry Reid of Nevada, told reporters.

The tax proposals, however, could galvanize Republican opposition and give conservatives a concrete target for taking on Mr. Obama, who despite his political strength could find some members of his own party reluctant to embrace tax increases.

Senator Max Baucus, Democrat of Montana and chairman of the Senate Finance Committee, who has been drafting a health plan, predicted in an interview that the Senate could pass legislation by its August recess.

Mr. Baucus acknowledged that ''there has to be revenue'' to offset the costs of expanded coverage initially, but he did not endorse the proposal for limiting wealthy taxpayers' deductions.

''There will be lots of options to pay it, not necessarily that one,'' Mr. Baucus said.

He would not say what revenue options he would support. But he said tax increases of some kind would not prevent some Senate Republicans from aligning with Democrats to pass a health plan.

In the House, the Republican leader, Representative John A. Boehner of Ohio, telegraphed his side's opposition to any tax increases.

''Everyone agrees that all Americans deserve access to affordable health care,'' Mr. Boehner said in a statement, ''but is increasing taxes during an economic recession, especially on small businesses, the right way to accomplish that goal?''

Mr. Boehner likewise criticized Mr. Obama's cap-and-trade emissions permits proposal, saying, ''Cap-and-trade is code for increasing taxes and killing American jobs,

and that's the last thing we need to do during these troubled economic times.''

To finance health care reform, administration officials suggested to senior aides in Congress on Wednesday that revenues could be raised by ending the policy of excluding the value of employer-provided health insurance from income taxes.

But the officials emphasized that the administration was not advocating that option, which not only is anathema to some in organized labor and business but also conflicts with Mr. Obama's position in last fall's presidential campaign.

The administration is proposing a number of other politically contentious ways of offsetting the costs of the health care initiative. Mr. Obama wants to require drug companies to give bigger discounts, or rebates, to Medicaid, the health program for low-income people.

Drug makers now must provide Medicaid with a discount equal to at least 15.1 percent of the average manufacturer price for a brand-name product. Mr. Obama wants to require discounts of at least 22.1 percent. Pharmaceutical companies have strenuously resisted such proposals in recent years.

Mr. Obama will also propose cutting Medicare payments to health insurance companies that provide comprehensive care to more than 10 million of the 44 million Medicare beneficiaries. He says he can save $175 billion over 10 years with a new competitive bidding system, under which payments to private Medicare Advantage plans would be based on an average of the bids they submit to Medicare.

Mr. GRASSLEY. In the top line, the article says: ''President Obama will propose further tax increases on the affluent to help pay for . . . health care reform.''

I am highlighting this article because the President is also proposing to take away a portion of a person's tax deduction. The President wants to limit the itemized deductions people making more than $250,000 a year can take. The only difference between the two proposals is the medical expense deduction limitation affects people who make less than $250,000 a year—the same class of people the President promised in the election he was not going to increase taxes on.

So, again, do not take my word for it. Data from the Joint Committee on Taxation tells us that in the year 2013, the largest concentration of taxpayers claiming the medical expense deduction will earn between $50,000 and $75,000—people who never thought they were going to have their taxes increased based upon what the President said during the campaign.

The analysis shows, a good number of taxpayers earning between $75,000 and $200,000 also claim the medical expense deduction.

My friends on the other side of the aisle will argue that their government-subsidized tax credit for health insurance will wipe clean any new taxes for those people below 400 percent of poverty. They will also argue that people purchasing insurance through the new exchange will be protected from catastrophic expenses as a result of annual out-of-pocket limits. For this reason, my friends on the other side argue those middle-class taxpayers will not need to rely on medical expense deductions.

I hate to break it to my colleagues, but the Congressional Budget Office—again, that god of Capitol Hill—estimates that in 2014 only 4 percent of Americans will be purchasing exchange insurance and only 3 percent of Americans will be receiving a tax credit. By 2019, when the Reid bill is in full effect, only 7 percent of Americans with exchange insurance will be receiving the tax credit. That leaves a heck of a lot of people below 400 percent of poverty with higher taxes.

What about those individuals and families above 400 percent of poverty? These people earn income below the President's magic $250,000 level, and somehow they do not qualify for this tax credit. What they do qualify for, though, is a tax increase. After all, there is reason why this proposal raises $15 billion over 10 years, and that is a heck of a lot of money.

Let me now turn to the third car of the tax increase express. This car is the high-cost plan tax. The Congressional Budget Office has consistently cited the two most powerful ways to bend the cost curve downward, meaning the cost curve of health care inflation: No. 1 is to cap the tax preference for employer-provided health coverage or the so-called exclusion; and, secondly, Medicare delivery system reforms.

A recent letter sent to the White House by respected economists also contends that placing a limit on high-cost employer plans would slow health care spending and reduce costs.

Well, some of my colleagues have come out squarely in support of a cap on the exclusion. That was an intellectually honest position. My friends, the chairman of the Budget Committee and the chairman of the Finance Committee, took the intellectually honest position. The Democratic leadership, however, has squarely opposed a cap on the exclusion. They argue that a cap on the exclusion would hurt middle-class workers.

But in a sleight of hand, this bill—this 2,074-page bill—and its authors, the Democratic leadership, came up with a proposal that would tax insurance companies for offering high-cost plans. It is a more complicated way of taxing the same workers. It is a sleight of hand because the Democratic leadership knows the tax will be passed through to the worker.

My friends simply did not want to say they were taxing the workers directly. So they have decided to tax those same workers very indirectly. In the end, the worker would be paying the tax, and these workers would be middle-income workers.

Again, do not take my word for it. The Joint Committee on Taxation testified before our very Senate Finance Committee that the high-cost plan tax would be passed on to whom—the workers.

Joint Committee on Taxation data also indicates that in 2019, 84 percent of the revenue generated from the high-cost plan tax comes from—guess who—individuals and families earning less than $200,000 a year, contrary to the President's promise in the last campaign that these folks would not pay any additional tax.

So whether you agree or disagree with the policy of limiting the tax benefit for employer-provided coverage, middle-class workers would see a tax increase.

Let's go to the fourth car of the tax increase express. This car is going to carry two new tax increases. The first tax increase is on workers who contribute to a flexible spending account, better known as an FSA.

Under the current tax laws, a worker may contribute to an FSA on a pretax basis and use those FSA contributions to pay for copays and deductibles tax free. Currently, there is no limit on how much a worker may contribute to an FSA. This 2,074-page bill, put together by Senator REID, would limit the contribution amounts to $2,500. Statistics show, the average FSA contribution is $1,800 a year. So this $2,500 limit does not sound that bad, right? Well, I say wrong. A great number of workers who have serious illnesses contribute significantly more than $1,800 and, let me say, more than $2,500.

On average—on average—these workers whom I am talking about with serious health problems earn about $55,000 a year. If I were to connect the dots, I would see a tax increase on workers with serious illnesses who earn $55,000 a year. Well, here is how. These workers would now have to pay taxes on their FSA contributions in excess of $2,500. The Democratic leadership is taxing health benefits for the first time ever—at least this benefit for the first time ever.

The second tax increase in this fourth car is the elimination of the taxfree reimbursement for over-the-counter medicine. Under the current tax rules, payments for over-the-counter medicine may be reimbursed taxfree if a worker is covered under a flexible savings account or under a health savings account. This 2,074-page bill takes away that tax benefit.

The fifth car of the tax increase express is the new Medicare payroll taxes. Since the New Deal, the United States has put into place several social insurance programs. They are part of the social fabric of America. Included in those programs are Social Security, unemployment insurance, and Medicare. They are all founded on the social insurance concepts. As Senator Moynihan, when he represented New York, used to remind us, to ensure their constitutionality, these programs were designed to be financed with payroll taxes instead of insurance premiums. But to maintain the closest appearance possible to social insurance, the payroll tax looks a lot like a premium for insurance.

This analogy is very intentional. It is not accidental. It is bedrock to the sustainability and universality of social

insurance programs that we all support: Social Security on the one hand, Medicare on the other.

The Reid amendment breaks that precedent, muddies the premium analogy, and could start us on a tax-hike-only journey to dealing with our unsustainable entitlement programs.

Let me explain that. The way the payroll tax works now is that every worker pays in based on his or her salary, wages, or small business income. That is a single, simple, and consistent tax base. Also, one tax rate applies to that payroll tax base. Now, for the first time—for the very first time—an additional second tax rate will apply to the payroll tax base. Also, for the first time in the almost 45-year history of this great social insurance program, we have before us a proposal that creates a marriage penalty in the payroll tax. Now think of the negative comments you get from a marriage penalty from grassroots America. So here we have a proposal that creates such a marriage penalty in the payroll tax. In other words, some married couples will be paying higher payroll taxes due solely to the fact that they are married. A tax on marriage? This is a direct result of this addition to the second tax rate.

Here is another matter that boggles the mind. The second tax rate kicks in if your wages exceed $200,000 if you are single and $250,000 if you are married. These dollar thresholds are not indexed. They are not indexed, so what happens then when you have inflation?

Another tax where the tax base is not indexed is the AMT. That ought to bring back all the horror stories about not indexing something timely when you first pass it. I think every Member of Congress knows that is an annual problem for us. In the late 1990s, commentators called the AMT the tax system's ''ticking timebomb.'' Fortunately, my friend, the chairman, and I started to diffuse this bomb in the 2001 tax legislation. It appears that my friends on the other side of the aisle have created another tax system ticking timebomb problem.

Finally, we have a caboose of this tax increase express. The caboose is the individual mandate penalty tax. It is a tax. It can be called a penalty, but it is a tax. All you have to do is have the IRS collecting it, as it does, and you know it is a tax. President Obama does not want to acknowledge that the penalty for failing to maintain a government-approved health insurance program is a tax, but it is right here in black and white. The Reid bill amends the Tax Code by adding a new excise tax. It is payable by those Americans who do not purchase government-approved health insurance.

I ask unanimous consent to place section 1501 of the Reid amendment in the RECORD, which adds this new excise tax to our tax laws.

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

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the ''requirement'') is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(H) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

''CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

''Sec. 5000A. Requirement to maintain minimum essential coverage.

''SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

''(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

''(b) SHARED RESPONSIBILITY PAYMENT.—

''(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

''(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

''(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

''(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

''(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

''(c) AMOUNT OF PENALTY.—

''(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to ½ of the applicable dollar amount for the calendar year.

''(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

''(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.

''(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

''(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of

a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

''(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

''(i) $750, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

''(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

''(i) the modified gross income of the taxpayer, plus

''(ii) the aggregate modified gross incomes of all other individuals who—

''(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

''(II) were required to file a return of tax imposed by section 1 for the taxable year.

''(C) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

''(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

''(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

''(iii) determined without regard to sections 911, 931, and 933.

''(D) POVERTY LINE.—

''(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

''(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

''(2) RELIGIOUS EXEMPTIONS.—

''(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

''(B) HEALTH CARE SHARING MINISTRY.—

''(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

''(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

''(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

''(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

''(III) members of which retain membership even after they develop a medical condition,

''(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

''(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

''(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

''(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

''(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

''(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

''(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

''(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

''(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

''(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

''(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

''(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

''(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

''(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

''(4) MONTHS DURING SHORT COVERAGE GAPS.—

''(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

''(B) SPECIAL RULES.—For purposes of applying this paragraph—

''(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

''(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

''(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

''(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

''(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

''(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

''(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

''(i) the Medicare program under part A of title XVIII of the Social Security Act,

''(ii) the Medicaid program under title XIX of the Social Security Act,

''(iii) the CHIP program under title XXI of the Social Security Act,

''(iv) the TRICARE for Life program,

''(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

''(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

''(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

''(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

''(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

''(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with

the Secretary, recognizes for purposes of this subsection.

''(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

''(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

''(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

''(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

''(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

''(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

''(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

''(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

''(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

''(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

''(g) ADMINISTRATION AND PROCEDURE.—

''(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

''(2) SPECIAL RULES.—Notwithstanding any other provision of law—

''(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

''(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

''(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

''(ii) levy on any such property with respect to such failure.''.

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

''CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

Mr. GRASSLEY. The kicker here is that CBO has told Congress that roughly one-half of those Americans who will pay this tax are individuals between 100 and 300 percent of poverty. These folks earn less than $250,000 a year. I see the light at the end of the tunnel that this tax increase express is going through. Unfortunately, that light at the end of the tunnel is the tax increase express.

We can derail the tax increase express if we want to.

That is why today I am supporting Senator CRAPO's motion to commit the Reid amendment to the Senate Finance Committee. Senator CRAPO's motion would require the Finance Committee report a bill back to the Senate that does not include tax increases, fees, and penalties included in the Reid bill.

Why should my Democratic friends vote in favor of the motion? Because they shouldn't want to bear the fallout of legislation that was rushed through Congress as the economic stimulus package was back in February. They shouldn't want to tell their constituents they voted in favor of a bill that increased their premiums. They shouldn't want to vote for a bill that raises taxes on many, only to provide benefit for a few. They shouldn't want to break President Obama's pledge not to tax people making less than $250,000 a year.

What my friends should want is real health care reform, the kind of reform that has broad bipartisan support. I have consistently said that if Congress wants to restructure one-sixth of the economy, it ought to be done on a bipartisan basis, and that is not one or two Republicans voting with Democrats. That is not happening around here on a bipartisan basis. We are debating this 2,074-page bill, a partisan product, a bill that was cobbled together by the Democratic leadership, a bill that has not received approval of the Senate Finance Committee.

I ask my Democratic friends to stop this process foul right now. Vote in favor of Senator CRAPO's motion so we can do health care reform in the right way: on a bipartisan basis, in a transparent and open way, so that the American public can understand what we are doing; so the American public can be a part of the process; so that we can find a way to reform our health care system without burdening our constituents with these higher taxes, fees, and penalties.

Let's reduce the out-of-control spending in the Reid amendment and find savings within the health care system. Let's derail the tax increase express before it steamrolls over hard-working Americans and discourages employment, particularly employment in small business, where 70 percent of the new jobs are created. The taxes, fees, and penalties don't need to be the fuel of this locomotive fire.

I ask all of my colleagues to support Senator CRAPO's motion to commit the Reid bill to the Finance Committee.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Madam President, the amendment we are now considering is an amendment I have offered that deals with drug importation; that is, the importation of prescription drugs from other countries. One might ask the question: Well, why would we want to import drugs from other countries? FDA-approved drugs are made all over the world and they are shipped all over the world; again, FDA-approved drugs, approved by our Food and Drug Administration, produced in plants that are inspected by our Food and Drug Administration. The difference is—the only difference is—when they are shipped around the world, the American consumer is charged the highest prices in the world by far.

Here is an example of the drug Lipitor. There are plenty of examples and I will go through a number of them today, but this is an example of Lipitor. For an equivalent amount of Lipitor, 20 milligram tablets, the U.S. consumer pays $125, the British pay $40, the Spanish pay $32, the Canadians pay $33, the Germans pay $48. We are charged the highest prices in the world for Lipitor. Lipitor, by the way, is the most popular cholesterol-lowering drug. I have a couple of empty bottles in the desk drawer here that demonstrates this drug was produced in Ireland. It was sent all around the world. The same pill put in the same bottle made by the same company, approved by our Food and Drug Administration, this was sent to Canada, this was sent to the United States. The difference? Well, the American consumer was allowed to pay three times as much as the Canadian consumer. I shouldn't say ''allowed,'' I should say forced. But it is not just United States versus Canada. As we can see, it is United States versus every other country.

The question is, Should that be the case? Should the American consumer be charged the highest prices in the world? My answer to that is no. Why is it the case that we are charged the highest prices in the world? Because we are the only country in which there is a special little law that prevents our citizens from accessing that FDA-approved drug from wherever it is sold at the most advantageous price. We have a provision in law that says the American people don't have the freedom to import a prescription drug, an FDA-approved drug that they find for half the price or 20 percent of the price in some other country. I say, give the American people the freedom. I hear so much discussion on the floor of the Senate about freedom. This is the ultimate freedom: the freedom of the American people to access those prescription drugs that are sold virtually everywhere else, brand-name prescription drugs at the fraction of the price.

I have examples of other prescription drugs as well to show you. It is not just Lipitor, although Lipitor is the most popular cholesterol-lowering drug.

This is Plavix. Plavix is an anticoagulant. You will see that we pay higher than all of these countries by

far; more than double what the British pay, more than double what the Spanish pay.

This is Nexium. If you are someone who has ulcers and you are taking Nexium, for an equivalent amount of the same drug, Nexium, you are charged $424 if you are an American citizen, $40 for the British, $36 for the Spanish, $37 for the Germans, $67 for the French. The American consumer, trying to control their condition of ulcers, pays $424—10 times the amount of money that others are paying for the identical drug—10 times.

This kind of what I believe is gouging—that is, a pricing strategy that gouges the American consumer—can largely be resolved by the amendment I have offered. It removes that little sweetheart impediment in law and says to the American people: You may import prescription drugs that are FDA-approved from registered enterprises in other countries. We specifically delineate which countries those are—there are a handful of them—that have a nearly identical drug approval process that we have in our country. Identical. We also put in this amendment unbelievable safety provisions dealing with pedigree and batch lots and tracers that don't exist now in our domestic drug supply, let alone importation.

So if we were allowing the American people to do this, the Congressional Budget Office says my amendment will save $19 billion—$19 billion—for the Federal Government over the next 10 years, but about somewhere around $80 billion for American consumers above that. That is a pretty big savings.

Here is another chart that shows what has happened in addition to the fact that we are charged the highest drug prices in the world. What has happened in recent months, in 2009, is that brand-name prescription drugs have increased in price over 9 percent, at a time when there is virtually no inflation. For Enbrel, for arthritis, you get to pay 12 percent more; for Singulair, 12 percent more; and for Boniva, for osteoporosis, by the way, you are paying 18 percent more just this year. That is what is happening. There is nothing in any of the health care plans considered by the Senate or the House that addresses the escalating price of prescription drugs.

There are a whole lot of folks in this country who are not senior citizens and are taking drugs to manage their disease. They may take cholesterol-lowering medicine or medicine to lower their blood pressure. They manage their health issues, and they don't have to go to a hospital because they are doing the right things. They are doing it with pharmaceuticals. The problem is, pharmaceutical prices are going up, up, up, way up above what other people in the world are paying for the identical drugs. I am saying it is just not fair. The issue is not that the pharmaceutical industry is a bad one or that they are infested with bad companies. I just think they have bad pricing policies. They are able to, and therefore they do, charge the American people, by far, the highest prices in the world.

I wish to talk about a couple of important issues with respect to this issue of giving the American people the freedom to access or purchase that FDA-approved drug in selected countries in which the drug safety regulatory system is identical to ours, which is in our bill. And our bill includes, as I said, the establishment of pedigrees for batch lots and tracers that don't exist today for our drug supply.

Some say and allege that you cannot do this safely, that it causes all kinds of problems with counterfeiting and so on. The fact is, the Europeans have been doing it safely for 20 years. For over two decades, in Europe, under what is called parallel trading, if you are a German and want to buy a prescription drug in Spain, you can do it through the parallel trading system. If you are in Italy and you want to buy a prescription drug from France, there is no problem, you can do it. They have done that safely for a long time. To suggest that we don't have the skill and capability to do what the Europeans have been doing routinely for 20 years is, in my judgment, shortchanging our country and certainly our consumers. I think we will, however, have people allege again that this is risky, it is just risky.

I would like to make a point about risk because I want to demonstrate something that I think most people don't know. Forty percent of the active ingredients of our existing prescription drugs come from China and India. Again, 40 percent of those active ingredients come from China and India and in most instances from areas that have never been inspected. My amendment doesn't allow drugs to be imported into this country from China or India. I am talking about the ingredients the pharmaceutical industry acquires with which to make their drugs. We don't allow drugs to be imported from China or India as a matter of this amendment; only FDA-approved drugs from FDA-inspected plants in Canada, the European countries, Japan, New Zealand, or Australia. That is all. Why? Because they have similar drug safety standards. That is the basis on which we determine how importation could work safely.

I wish to describe a recent scandal that illustrates the double standard some want to apply to this question. The scandal was about a drug called Heparin, a blood thinner that is commonly used by dialysis patients, which was linked to more than 62 deaths last year. Heparin was ultimately pulled from the market. According to Baxter, which markets Heparin in the United States, the allergic reactions to Heparin that caused the deaths appear to be caused by a contaminant added in place of the active ingredient in Heparin somewhere during the manufacturing process, most likely in China.

The Wall Street Journal did a very important story on the Heparin contamination. They reported that more than half of the world's Heparin gets its start in China's poorly regulated supply chain. This is what the Wall Street Journal, after its investigation, concluded:

> More than half of the world's Heparin, the main ingredient in this widely used anticlotting medicine, gets its start in China's totally unregulated supply chain.

The Wall Street Journal published a series of pictures that I want to show—photographs of the intestine encasing factory which processes pig intestines used to make Heparin. I want to show some photographs that came from the Wall Street Journal. This is a photograph of a facility, and that is the outside. Here is a photograph of someone in the facility who is stirring a rusty vat full of Heparin ingredients with a tree branch. So this is the processing of Heparin from pig intestines in a facility in China, in which a worker is stirring this rusty vat with a tree branch. Are the ingredients that are used to make medicine with respect to blood clotting an issue?

When the industry and others say we can't have drug importation safely from Canada or Ireland, the point is that they are getting a lot of their ingredients from China and India. All you have to do is simply look at this and ask yourself whether the domestic drug supply with respect to that ingredient and those inputs has sufficient safety.

While the record keeping at these Chinese facilities makes it almost impossible to trace the contaminant from this particular factory, these pictures by the Wall Street Journal show the unsanitary conditions in which pig intestines are processed for that particular medicine. Again, by contrast, the amendment we offer would allow the importation of FDA-approved medicines only, with a chain of custody to ensure the drugs are handled properly. It gives the FDA the authority to inspect all facilities in the chain of custody.

The amendment mandates the use of anticounterfeiting technology to track and trace imported and domestic drugs to ensure product integrity. That doesn't exist today, but that is required in the amendment. The amendment also requires pharmacies and drug wholesalers to register with the FDA and to be subject to strict requirements to ensure the safety of imported medications, including frequent random inspections.

The amendment I am offering would ensure safety and, in fact, provide a much greater margin of safety than now exists with all of our drug supply. We need to have these improvements, in my judgment, because our own prescription drug distribution system is not as good as we think it is.

Here is an excellent example of something that took place in the United States. This is a picture of Mr. Tim

Fagan, a young 16-year-old boy from Long Island, NY. He received a liver transplant. He was prescribed a drug called Epogen to boost his red blood cells and fight the anemia after the operation. He received daily inspections, but his red blood cell count wasn't improving and the doctors could not figure out why, what was happening. After 2 months, his mom went to the local CVS pharmacy, where she was told: By the way, the Epogen your son has been taking may have been counterfeit.

Here is an example of counterfeiting in the existing domestic drug supply—counterfeiting in which this container held the counterfeit medicine and this one held the real medicine. There were subtle differences but not many. It turned out that the vial Tim was injecting was one-twentieth the strength of what he was supposed to be taking and what was disclosed on the label.

How did that happen? The weaker drug sells for $22 a bottle, and the high-strength version goes for $445 a bottle. Investigators found that 110,000 of the bogus bottles of that medicine reached the market in this country, and it is estimated that the criminals involved with that counterfeiting in that particular case made $46 million.

The manufacturer of that drug, a company called Amgen, had distributed some of the product through a complicated network of secondary distributors. Although nobody knew it at the time, some of the Epogen that was eventually resold had most likely run through a cooler in the back of this strip club, a seedy Miami strip club called Playpen South.

Here is a chart that shows the distribution system this particular counterfeit drug went through. Again, this is not an import; this is a domestic drug. You can see this unbelievable and complicated distribution system. At the end of that, it traveled through strip clubs, through homes, and through trunks of cars without proper cooling.

This story was told in great detail by some outstanding investigation by Katherine Eban in a book called ''Dangerous Doses.''

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

Mr. DORGAN. I ask unanimous consent to extend the period of debate until 3 p.m., with the time to be equally divided, with Senators permitted to speak therein for up to 10 minutes each, with no amendments in order during this time.

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

Mr. DORGAN. I ask unanimous consent to speak for as much time as I may consume.

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

Mr. DORGAN. Mr. President, again talking about the issue I just described:

They traveled through strip clubs. They traveled through homes. They traveled through trunks of cars, without proper cooling.

I am talking about a domestic counterfeit drug supply.

The amendment we are offering would fix this supply chain problem. It will require a pedigree for all drugs, not just those imported. It should have been done long ago. Some of us have been trying for a long time. It will allow us to track every single drug from where it is made to the pharmacy in which it is sold.

My amendment will require a set of anti-counterfeiting measures that are not in place now. If you think of it, I have a twenty-dollar bill here, and most people who have looked at them understand there is sophisticated and substantial anti-counterfeiting technology in new twenty-dollar bills. That doesn't exist today, by the way. That sophistication, that relentless search for the ability to detect counterfeiting does not exist today, regrettably, in our drug supply. The pedigree that we require, the tracing capability, the batch lots will make that a requirement on our entire drug supply.

This amendment will make our entire drug supply safer. It will allow Americans to benefit from lower prices—the prices at which these identical drugs are sold in other countries. In many cases they are half the price and in some cases much lower—10 percent of the price at which they are sold in this country.

I wish to talk for a moment about the issue of drug price inflation because the drug price—what is happening to us in this country is drug price inflation, the relentless increases year after year, which is the red line here on the chart. It is 9.3 percent this year. This yellow line is the rate of inflation. If we don't do anything to deal with the price of prescription drugs, we will have missed the opportunity to do something to help the American people.

Let me describe a few stories about the need for the amendment.

In my home State, in Aneta, ND, Maryanne wrote to me:

My husband has Parkinson's Disease, so he takes a drug called Mirapex. We have Medicare Part D, but in September, he ends up in the so-called donut hole. In 2008, when this happened, we paid $106 for his medication. It increased to $187 in October and November, $198 in December. Now, in September 2009, the price was $286—a $180 increase in one year.

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

Mr. DORGAN. Yes.

Mr. MCCAIN. The Senator, I know, is aware and has talked about this. How does the Senator account for the fact that there is a nearly 9-percent increase in the cost of pharmaceutical drugs, while the consumer price index this year has gone down 1.3 percent?

I understand this is the highest increase in the history, or in most recent years, in the cost of prescription drugs. What is the explanation between the divergence of those two lines?

Mr. DORGAN. The explanation, I suppose, is probably better addressed to the pharmaceutical industry of how and why do they increase these prices this way. My guess is they do it because they can.

The fact is, the cost-of-living index—the inflation rate is the yellow line. The price of prescription drugs is the red line.

Mr. MCCAIN. Would that have anything to do with the anticipation of incoming reductions or reductions in the increase of costs of pharmaceuticals?

Mr. DORGAN. I say to the Senator from Arizona, my expectation is the pharmaceutical industry has said this is the time to increase these prices. The most important element is there is no restraint. No one has any capability of restraining them. The only way you would provide restraint on this is if you said to the American consumer: You know what. You don't have to buy it from these people at these prices because it is sold in virtually every other country at half the price. If we say to the American people, we will give them the freedom to access that drug elsewhere, I think quickly the pharmaceutical industry would not be able to impose those price increases because then you would have competition. Freedom equals competition, in my judgment, on this issue.

Mr. MCCAIN. May I ask the Senator another question. We understand you can buy lettuce from overseas. You can buy many other products from overseas. You can buy dairy products. You can buy almost any item except perhaps prescription drugs. Yet the Canadians, in particular, as well as the countries that are included in the Senator's amendment, all adhere to the same standards or higher standards than the United States of America does.

Now I understand one of the Senators—not the Senator from North Dakota—has received a letter saying this is still a problem.

I don't get it. Maybe the Senator from North Dakota can explain it a little better.

Mr. DORGAN. I say to the Senator from Arizona, there is not a safety issue here. To the extent there is any safety issue, it is that we intend to increase the safety of both domestic supply of prescription drugs and the imported prescription drugs because the fact is, there is nothing at this point dealing with batch lots and pedigrees and tracing capability. That does not exist at this point. We will insist on it in this amendment.

For anybody to suggest that somehow we are going to end up with prescription drug products that are less safe, that is just not the fact. As I indicated before the Senator came to the floor, Europe has been doing this for 20 years in something called parallel trading. For 20 years, they have done it. If you are in Germany and want to buy a prescription drug that is approved, you can. If you are in Italy and want to buy

it from France, you can. They do it successfully.

I do not believe anybody should tell us we are not capable of doing what the Europeans have done for 20 years, and that is giving people the freedom to access prescription drugs where they are sold at a better price.

Mr. MCCAIN. May I ask the Senator another question. Isn't it true a letter was written to one of our colleagues from the Administrator of the FDA, the organization that would basically make sure any product that goes to American consumers along these lines, that go through that bureaucracy, said it would require a significant amount of assets and resources?

I have since been told there are 11,000 employees of that bureaucracy. I wonder what he thinks about that argument; and, again, was the Senator from North Dakota informed about this position, which, by the way, is the same position as the previous administration?

Mr. DORGAN. Madam President, the Senator from Arizona is correct. There was a letter from the Food and Drug Administration. The fact is, we have seen this over the years. They say: We don't have the resources or it will pose more risk.

The fact is, this amendment provides the resources for them because those who are going to register to ship FDA-approved drugs into this country at a better price are going to have to pay a fee. The people who are selling will pay a fee, and those pharmacies and others in our country that will be receiving them will also pay a fee.

Mr. MCCAIN. So it would require no additional funding from the taxpayers.

Mr. DORGAN. No additional funding from the taxpayers at all. Those who decide they are going to offer these lower price prescription drugs would be paying a fee for the purpose of being able to do that. This is not a taxpayer-funded issue at all. It will provide the additional resources and pay for those resources without asking the taxpayers to come up with the money.

Mr. MCCAIN. Do these countries that are included in the Senator's amendment—do we have absolute assurance, can we look at the American people and say: Those countries and the agreements we would have with them, you can have products that are safe, you can safely buy, and it would not pose any hazard to anyone's health?

Mr. DORGAN. The countries that are involved in this amendment—and they are limited—are countries that have nearly identical drug safety standards to our country. These are countries that are accessing the same drugs.

I just mentioned—let me do it again—two bottles of medicine. They are empty, obviously. Both of these bottles contain Lipitor. Most of my colleagues know what Lipitor is. This was made by an American company in Ireland and then shipped all over the world. This little bottle was shipped to the United States. This little bottle was shipped to Canada. Same bottle. One was blue, one has red in the label. Same bottle, same company, inspected by the FDA. What is the difference? The price.

The American consumer is told: Guess what you get to do. You get to pay almost triple. Why? And it is not just the American consumer, if I can hold up a chart that shows two drugs—one is Nexium. This is advertised substantially. Nexium is an example. I also have one on Lipitor. Here is the price for Nexium.

Do you think the pharmaceutical industry is selling Nexium at $37 for the equivalent quantity in Germany and losing money? I don't think they are losing money at that. Instead of $37, they charge the American consumer $424.

My point is my beef with the industry is their pricing policy.

Mr. MCCAIN. Wouldn't the pharmaceutical companies say it costs $424 because we have to absorb the cost of all the research that went into developing Nexium?

Mr. DORGAN. I would say that is also always raised. They say: If you don't allow us to charge the American consumers the highest prices in the world, we don't get to do the research and development that produces the next new miracle drug.

Most of the recent studies have shown that the pharmaceutical industry spends more money on promotion, marketing, and advertising than they do on research. I want them to do research. But there is one other piece. The Congress gave, without my support, a proposal that said those American companies that have money overseas should bring it back and we will let them pay a lower tax rate. Guess which industry was one of the largest industries with repatriated profits from abroad? The pharmaceutical industry. If they are making big profits abroad and charging lower prices to those consumers abroad, why can't the American people have access to those prices?

It is not because they are going to lose money because they made a lot of money abroad. That is why they repatriated at a lower rate.

Mr. MCCAIN. Do the seniors from his State and other citizens from his State travel to Canada and buy these prescription drugs because they know and are confident that they are getting, at a much lower price, the same product? Unfortunately, citizens in my State have to go south, and it is unfortunate when they have to do that because we do have a much larger problem there, I am sorry to say.

Mr. DORGAN. Madam President, the citizens from North Dakota often have to go to Canada to buy a prescription drug. I have told the story about the old codger who was sitting on a hay bale in a farmyard when I had a town meeting. He was nibbling on a piece of straw. He said to me: My wife—he was about 80 years old—my wife has been fighting breast cancer for 3 years. He said: The only way we could pay for our prescription drugs was to drive to Canada once every 3 months because when you buy tamoxifen in Canada, you pay like one-tenth the price or one-fifth of the price you pay in the United States. He said: We did that every 3 months so my wife could keep fighting breast cancer.

Of course they do that. What is happening is consumers are allowed to bring back as an informal strategy about 90 days' worth of supply of prescription drugs for personal use only. Most American consumers cannot do that. They do not live anywhere close to a border.

The question is, Can the rest of the American people have access to the same prescription drugs sold at a fraction of the price?

Mr. MCCAIN. May I ask the Senator, isn't it true the Congressional Budget Office has determined that this measure of the Senator from North Dakota, this modest measure of only countries that are of the highest level of quality of inspection, of all the standards that we have, would save the American consumer $100 billion; is that true?

Mr. DORGAN. Madam President, the Congressional Budget office says it will save the Federal Government about $19 billion, and then about another $80 billion will be saved by the consumers. That is about $100 billion, nearly $100 billion in savings in total, $19 billion of which will be saved by the Federal Government for its purchases, and the rest by the American consumers.

Mr. MCCAIN. Finally, I wish to ask the Senator, what is the basis of the argument against the Senator's amendment? What possible reason, frankly, except for the influence of a special interest in this, our Nation's Capitol?

Mr. DORGAN. I am not a very good advocate for the other side. If one were to ask what is the best argument opposed to my amendment, I would say there are not any arguments that are the best. There is a range of poor arguments or arguments that do not hold much water.

I started by saying I do not have a beef against the pharmaceutical industry. I want them to do well. I want them to be successful. I want them to keep finding and searching for miracle drugs. By the way, much of the work they do comes from the National Institutes of Health and the massive investments we make in health. I want them all to be successful.

My beef with them is a pricing strategy that says to the American people: Here is what you pay, and you can do nothing about it because we decided that is what you pay, and we are going to offer everything around the world at lower prices. That is my beef. This is a pricing issue. They are wrong about it.

The way to correct it is to give the American people a little bit of freedom. We will save money for the government and save money for the American people.

I want to raise one additional point while the Senator is here. If the Senator from Arizona is like me, when I am brushing my teeth in the morning, I have a television blaring and I hear all these ads: Go ask the doctor if the purple pill is right for you. I haven't the foggiest idea what a purple pill will do for me. The ads are so compelling you almost feel: I have to get out of here. I have to stop brushing my teeth, go get a phone, and call my doctor to see if my life might be improved by taking a purple pill.

I read a whole series of advertisements:

Does your restless mind keep you from sleeping? Do you lie awake exhausted? Maybe it's time to ask if Lunesta is right for you. Ask your doctor how to get 7 nights of Lunesta free . . .

I read a bunch of these. I will not now. Bladder problems, Flomax, Ambien—you name it and they advertise it all day and every morning. I say knock off a little of that. Give us some better prices. God bless you for doing all you do, I would say to the industry, but give us fair prices. Give fair prices to the American consumer and knock off a little of the advertising. The advertising is only for a product that only a doctor can prescribe. You cannot get this product unless a doctor thinks you need it. Stop asking me if the purple pill is right for me, asking me to ask a doctor if the purple pill is right for Senator MCCAIN. Knock it off.

Mr. MCCAIN. Mr. President, I ask unanimous consent to make an additional comment.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). Without objection, it is so ordered.

Mr. MCCAIN. I thank the Senator from North Dakota who has been pursuing this issue for a number of years. I believe we are on the verge of success.

I appreciate his eloquence, I appreciate his passion, but most of all, on behalf of the citizens of my State who can't get up to Canada, who now are experiencing unprecedented economic difficulties, and who need these lifesaving prescription drugs—many of them senior citizens—I just wish to say thank you for your advocacy.

I think you have made an eloquent case, and I hope my colleagues have paid attention and will vote in the affirmative for the Senator's amendment today.

Mr. DORGAN. Mr. President, let me say that Senator MCCAIN has been a part of this effort for a long time. It is interesting, with all the action on floor of the Senate in recent weeks, this is one of the few examples of a significant policy that is bipartisan. We have Republicans and Democrats—over 30 cosponsors—who have worked with us to make certain we can do this, do it safely, and give the American people the opportunity they deserve. This is very bipartisan. I appreciate that a lot.

I wish to say, the National Federation of Independent Businesses supports this; the AARP supports this. We have a long list of organizations that are strong supporters of this amendment, and so I hope, today, perhaps at last—at long last, after 8 or 10 years—we might finally achieve a breakthrough and get this through the Senate.

I have said previously that the pharmaceutical industry is a formidable opponent. I understand that. We have had difficulty getting this in a piece of legislation to get it signed and give the American people freedom and give them fair pricing. When we do this—Senator MCCAIN, myself, and others—it is suggested that somehow we have no regard for this industry. That is not the case at all. It just is not. We have no regard for a pricing policy, however, that we believe is unfair to the American people. It has been that way for too long—a long time too long. Perhaps today—with the vote on this amendment, which I expect later this afternoon—will be the first step in getting that changed.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. KYL. Mr. President, I believe if I am to speak for more than 10 minutes I need to ask unanimous consent. If that is correct, I ask unanimous consent to speak for 15 minutes.

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

Mr. KYL. Mr. President, I wish to speak to the Crapo motion—an amendment that, hopefully, we will be voting on a little later today—and I urge my colleagues to support the motion of the Senator from Idaho.

This is about jobs and it is about taxes. I think one thing Americans don't expect out of this legislation is that they are going to have a pay a lot of taxes and that jobs are going to be killed rather than created. The President is talking about creating more jobs. Everyone in America is focused on putting people back to work, ending this recession, and bringing unemployment down so we can get jobs and go back to work. One of the problems with this bill is it kills jobs. It kills job creation. One of the ways it does that is through the many new taxes and mandates it imposes.

Naturally, we want to be sure that whatever we do, we don't harm our economy or job creation, but this $2.5 trillion legislation is filled with new taxes and mandates that will ultimately be borne by small businesses and the American workers. I will talk about just three.

First, a new employer mandate that says that employers have to provide insurance to their employees or face a penalty. This would hurt low-income workers especially, according to a Harvard economist, and I will be talking about that.

Second, there is a new Medicare payroll tax. Incidentally, the revenue raised doesn't go back to Medicare. It would be nice if we could help with the Medicare solvency, but this too threatens the creation of jobs, particularly in small businesses, because it is a direct tax on hiring more people.

Finally, new taxes on the health care industry could undermine its ongoing job creation gains. By the way, it is the only industry to have gained jobs since the start of the recession and this legislation will actually cause job losses.

I will describe all three of these. First, the employer mandate. The bill imposes a requirement—a costly new mandate—on employers that will have the perverse impact of actually hurting employees, especially low-cost employees. How so? Any employer with more than 50 employees who does not offer health care coverage would be required to pay an assessment for each employee who receives a tax credit for purchasing coverage through a newly created exchange. Those are folks in the lower income brackets who qualify for tax credits. So this becomes a direct tax on hiring people.

According to the Center on Budget and Policy Priorities,

. . . the particular employee provision in the Finance Committee bill would pose significant problems by imposing a tax on employers for hiring people from low- and moderate-income families who would qualify for subsidies in the new health insurance exchanges, it would discourage firms from hiring such individuals, and would favor the hiring—for the same jobs—of people who don't qualify for the subsidies (primarily people from families at higher income levels.)

To conclude:

It would [also] provide an incentive for employers to convert full-time workers (i.e., workers employed at least 30 hours per week) to part-time workers.

So here you have it—a mandate in the bill that would directly impact the hiring of low-income workers—precisely the opposite of what we want to be doing these days.

Harvard economist Kate Baicker examined the effect of an employer mandate similar to the one in the Reid bill. She estimated the cost of hiring a low-wage worker would rise by 33 percent—or $2 per hour on a worker earning $6 per hour. Think about that. She concluded that 224,000 workers would lose their jobs as a result of a mandate with these costs.

In addition to all the other problems we have with growing unemployment, here is another one-quarter million people who would lose their jobs because of this bill. It makes no sense.

There was a recent letter sent to the two Senate leaders from the National Federation of Independent Businesses which states:

Mandates destroy job creation opportunities for employees. The job loss, whether through lost hiring or greater reliance on part-time employees, harms low-wage or entry-level workers the most.

That is exactly what the other study said. By the way, the NFIB is a nonprofit, non-partisan organization, defining itself as the voice of small business. We are all familiar with the good work it does. I think it would know

what is best for American business and workers.

The second way this bill imposes taxes and hurts workers is it actually creates a payroll tax; in other words, a tax on hiring people or keeping them on your payroll. It raises the Medicare payroll tax by 0.5 percent on small businesses with taxable receipts of $200,000 a year or $250,000 or more, if the small business employer filer is married.

Because many small businesses pay taxes at the individual level, imposing higher individual income taxes hurts these engines of job creation. The Joint Committee on Taxation recently estimated that one-third of the income that would be taxed under a similar House proposal comes from small businesses. Let us remember, as President Obama reminded us earlier this week, small businesses generated 65 percent of the job growth between 1993 and 2008 and represent about half the private sector employment of the United States.

So this huge potential engine for job creation is going to get whacked by the imposition of a new tax, which is a direct tax on the hiring or retaining of employees. The Joint Committee estimates that this increase in the Medicare tax would raise $54 billion over the next 10 years. That is $54 billion of resources that could have better been used in the private economy, in these small businesses, to expand job creation.

Each new tax dollar paid by these small businesses is one less dollar that could go toward the hiring of new employees or, for that matter, preventing layoffs or even giving raises to their existing employees.

A group of organizations recently told us in a letter—by the way, these are all organizations that represent small businesses in their communities—they oppose this bill because of what it would do to these small businesses. I wish to read the names of the groups that represent these folks: the Associated Builders and Contractors, the Associated General Contractors, the International Food Service Distributors Association, the National Association of Manufacturers, the National Association of Wholesaler-Distributors, the National Retail Federation, the Small Business and Entrepreneurship Council, and the U.S. Chamber of Commerce.

Here is a telling quotation from their letter:

> In order to finance part of its $2.5 trillion price tag, H.R. 3590 imposes new taxes, fees, and penalties totaling nearly half a trillion dollars. This financial burden falls disproportionately on the backs of small business. Small firms are in desperate need of this precious capital for job creation, investment, and business.

That is exactly what President Obama said yesterday. We have to get more capital into the hands of these small businesses so they can either continue their businesses with their employees or, potentially at least, soon begin hiring more. Yet as this letter points out, this bill imposes taxes with a burden that falls disproportionately on the very firms we are trying to help.

In a November 19 statement, the National Federation of Independent Businesses said of the bill's impact on small businesses:

> We oppose [the Reid bill] due to the amount of new taxes, the creation of new mandates, and the establishment of new entitlement programs. There is no doubt all these burdens will be paid for on the backs of small business. It is clear to us that, at the end of the day, the costs to small business more than outweigh the benefits they may have realized.

They go on:

> The impact from these new taxes, a rich benefit package that is more costly than what they can afford today, a new government entitlement program, and a hard employer mandate equals disaster for small business.

They know what they are talking about. These are the folks whom we are depending upon to create jobs and we are punching them right in the stomach, right where it hurts, with respect to their ability to create these new jobs with the new taxes and mandates imposed in this bill.

Let me share a brief letter from one of my constituents. He is a small business owner in Tempe, AZ. His name is Justin Page. He would like to be able to grow his business, but the burdensome new taxes in this bill would force him to lay off workers and cut hours from his payroll. Here is what he says:

> Dear Senator Kyl, As a long time Tempe and Arizona resident, who has been operating a small business for the past 19 years, I urge you to not vote for the healthcare bill as it is currently proposed and as recently passed by the House of Representatives. My business has taken a severe financial hit in the past 18 months with several employee layoffs, reduced hours for current employees, heavier workloads, et cetera. My answer to increased health care costs and additional small business taxes is to lay more people off . . . not good for [my employees], and not good for me! But survival is my primary goal right now! Reform is necessary, but please do it in a bipartisan manner and within a timetable that allows for constructive debate. This is too important.

So small businesses have some very real concerns about this legislation and good reason to worry that they will be victims of its destructive policies. Obviously, it is not the kind of legislation small business owners or the American worker wants and, of course, not particularly in times of double-digit unemployment. We need to listen to the people out there who are actually creating jobs, who have to meet a payroll, balance a budget, and know what is necessary to run a successful small business. They are not happy with this legislation.

The third and final point is the new taxes on the health care industry, which of course get passed through to the people who ultimately have to buy insurance. Let me just discuss one—the medical device tax. This medical device tax is a tax on things that are used to treat us, to give us health care every day. The $110 billion in new taxes on industries such as this—the pharmaceutical, the insurance, and medical device industries—is a direct pass-through in terms of what we will end up having to pay in insurance premiums.

For example, this medical device tax will be assessed against thousands of products, such as contact lenses, stethoscopes, hospital beds, artificial heart valves, and advanced diagnostic equipment. Why would you impose a tax on these things that help us? I could maybe see a tax against liquor or a tax against tobacco but a tax on things such as this—these advanced technologies that help us? Why do we want to make them more expensive? These have been invented so we can have an extension of our lives; so our families can have better health care.

We all know when you tax something, you get less of it. In fact, a UBS Investment Research paper recently confirmed:

> If the plan passes as proposed and our estimates are correct, the initial years would be a financial challenge for medical device manufacturers, as the full industry fee becomes due before newly covered patients impact volumes.

What they are saying here is, first, before they can even begin to pass these costs on, it could kill this particular industry.

These taxes will hit smaller firms particularly hard since some of the smaller companies don't start out with a lot of profits. They rely almost entirely for domestic sales on their revenues.

I note my colleagues on the other side of the aisle, Senators KLOBUCHAR, BAYH, FRANKEN, and in addition Senator LUGAR from this side of the aisle, recently sent a letter in which they said:

> Independent estimates indicate that this tax could translate into an annual income tax surcharge of between 10 and 30 percent on medical device manufacturers.

Think about that, a 10- to 30-percent tax on folks who are inventing these kinds of things to help us.

These Senators go on in their letter:

> This provision would harm economic development and health care innovation nationwide.

This was a letter to the chairman of the Finance Committee.

I know there some who argue that lost jobs in the private health care sector will be made up with new jobs in the government with health care bureaucrats here in Washington. Wonderful, I say.

That is not a good thing. We need jobs in the private sector. That should be our primary goal and that certainly is what President Obama was talking about yesterday when he talked about creating more jobs in the private sector.

In conclusion, I have described three ways in which this legislation through its mandates and its new taxes will

cripple our ability to come back out of this recession. It will make it very difficult for us to retain, let alone hire, new employees.

All of us here in the Senate I know want to do what we can to bring down the current very high unemployment. It is obvious that this health care bill makes things worse, not better. At every turn its new taxes and mandates put us on the wrong course. I think it is very hard to justify support for this legislation that threatens job creation, especially job creation for low-income workers.

I urge my colleagues, when we vote on the Crapo motion here pretty soon, to consider its impact. It will enable at least people in the lower income levels to avoid the kind of taxes that are imposed here, one of which, for example, is the tax that IRS will enforce if you do not buy the insurance policy that the government, under this bill, will mandate that you buy. If you cannot afford the insurance the Government has, you have to buy it anyway. If you do not, we will impose a new tax on you, enforced by the IRS. The Crapo motion would say no, not so fast, IRS, we are going to protect folks from that new tax. That is why it is important to support the Crapo motion.

I urge my colleagues, even though I know we have had a lot of votes here where very few Democrats have supported Republican amendments, this is one which I hope all of us could support.

The PRESIDING OFFICER. The Senator from Wisconsin is recognized.

Mr. FEINGOLD. Mr. President, I rise in strong support of the amendment offered by Senator DORGAN. Frankly, this amendment should be a no-brainer—it saves taxpayers and consumers money by bringing down prices for prescription drugs. I don't think American consumers should have to pay the highest prices in the world for prescription drugs, particularly when those prices keep going up.

The Congressional Budget Office has stated that brand-name drugs cost, on average, 35 to 55 percent less in other industrialized nations than they do in the United States. And the AARP released a study recently that found that the price of drugs most commonly used by seniors has risen faster than the general inflation rate every year since 2004. In 2007, the price spiked by 8.7 percent—three times the general inflation rate of 2.9 percent.

It is no wonder that Americans turn to Canada to buy more affordable, and entirely safe, prescription drugs. Americans are now importing more than $1 billion in prescription drugs from Canada alone. Consumers would not go to such lengths to buy their medicines this way if they were not saving money.

Now, the drug industry has said that drug importation can't be done safely. I give PhRMA credit. They have gone to great lengths to scare the public. The reality is drug importation has occurred within European Union countries—called parallel trade—for the last 25 years. The pharmaceutical industry should know drug importation is safe. The industry has imported drugs and sold them in the U.S. for decades. One-quarter of the drugs consumed by Americans today are made in foreign manufacturing plants.

The Dorgan amendment includes a number of protections to ensure that imported drugs are safe—and certainly safer than the completely unregulated system we have today.

I don't need to remind my colleagues about the deficit hole we are in. Federal spending is one of the top concerns I hear about from my constituents—they want to know what we are doing to get our deficit under control. That is why I introduced legislation, the Control Spending Now Act, to propose concrete ways to bring down runaway government spending. And one of the proposals I included was Senator DORGAN's drug importation legislation, because it is such a commonsense and effective way to save the government tens of billions of dollars. I am pleased that the health care reform bill we are debating already includes three other proposals in my control spending bill, championed by Senator BINGAMAN and others, that would slash Federal spending on prescription drugs by billions of dollars.

With passage of the Dorgan amendment we can make it four.

We do a lot of things in Congress that leave our constituents scratching their heads. Now we have a chance to show them we are listening to them, that we understand their concerns, and that we want to bring down Federal spending while ensuring the prescription drugs they need are more affordable. Again, that sounds like a no-brainer to me.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask unanimous consent that we extend the period for debate until 4 p.m. with the time equally divided, with Senators permitted to speak up to 10 minutes each, with no amendments in order during this period of time.

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

Mr. ENZI. Mr. President, I yield myself 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, Americans across this country are facing the reality of an economy that is in trouble. The unemployment rate is now 10 percent. According to the Department of Labor's broadest measure, some 17.5 percent of Americans are without a job entirely or are underemployed.

We have shed 3½ million jobs since January of this year and the average work week is now down to 33 hours for the American worker. Americans are struggling to find good jobs and, because of that, they are having trouble making their mortgage payments. Fourteen percent of all mortgage loans, meaning 7.4 million households, were delinquent or in foreclosure in the last quarter. That is the highest number since the mortgage bankers industry began this survey in 1972.

Many economic indicators point toward a slow, unsteady and jobless recovery, and the American people know it. In a recent survey, 82 percent of Americans said our Nation's economic conditions are poor. In recent weeks, President Obama has convened a summit at the White House to discuss jobs and economic issues. He has given speeches to discuss proposals for job creation and economic recovery. There has even been discussion about spending additional billions of dollars on another economic stimulus bill.

Unfortunately, the President has not advocated for the single quickest and simplest way to promote economic growth. If the President wants to save jobs and grow the economy, all he needs to do is tell the majority leader and the Senate Democrats to scrap this $2.5 trillion Reid health care reform bill and work it over, step by step, to get it right and to save costs.

Senator REID's prescription for our economic troubles is a $2.5 trillion bill full of tax increases, higher health care costs, and $500 billion in Medicare cuts. The Reid bill contains $500 billion in new taxes. Primarily that is how it is being paid for—steal money from Medicare and tax people additionally. There are new taxes on individuals, new taxes on small businesses, and new taxes on health care providers.

These new taxes will raise health care costs. They will be passed on to the individuals in the form of higher premiums. According to the Congressional Budget Office, the Reid bill will drive premiums up by 10 percent to 13 percent.

I know the other side likes to relate to those pieces of the bill that talk about—one section that brings it down by 7 percent and another one that brings it down by 7 percent, but they fail to notice that the bill actually raises it to 27 percent to begin with. When you subtract that out, it still winds up with a 10-percent to 13-percent increase.

Who gets taxed under the Reid bill? If you don't have a government-approved health insurance, you get taxed. Incidentally, we are going to tell you—Washington is going to tell you what the minimum requirement is. That will be higher than most people have for insurance at the present time. The government will tell you what you need and they will fine you if you do not agree.

The total amount of new taxes on uninsured Americans is $8 billion. According to the Congressional Budget Office, half of the new taxes on the uninsured will be paid by families earning less than $68,000 a year.

If you do not have insurance, you will get taxed. If you have insurance, you can get hit twice by new taxes in

the Reid bill. First, new taxes on health care providers will be passed on to consumers in the form of higher premiums. Second, if the government bureaucrats decide your employer-sponsored insurance is too generous, you will get taxed for that too.

The Reid bill contains $150 billion in new taxes on employer-sponsored health benefits. These new taxes on benefits fall disproportionately on middle-income Americans. According to the Joint Committee on Taxation, 73 percent of those hit with new taxes on benefits earn less than $200,000—73 percent. That is a whole bunch of people down there in that category.

The Reid bill also contains new taxes on businesses that cannot afford to provide health insurance. Most employers do provide health insurance to their employees, but there are some who simply cannot afford to and stay in business. Senator REID's health care plan will mean they will have to pay $28 billion in new taxes. These are the same businesses that are barely making it. These are the same businesses that are having to lay off workers to keep the company afloat, the same businesses that are cutting shifts to prevent further layoffs, and they are cutting wages to keep their employees on the payroll.

With our Nation's unemployment in double digits and millions more Americans worried about keeping their jobs and paying their bills, it is unthinkable to me that any Member of this body would support new taxes on businesses that are already struggling. These are the small businesses that absorb the extra employees that get laid off from the big businesses—and hopefully it is the small businesses that become the future big businesses.

In addition to the job-killing taxes, the Reid bill raises Medicare payroll taxes by $50 billion. These will fall disproportionately on small businesses. Approximately one-third of America's small businesses will be hit with this tax increase. These are the same small businesses that employ 30 million Americans.

I have to say, when you talk about taxing the rich, we are also talking about taxing the owners of small business corporations, because the money flows right through to them, even though they have to put most of it back into the business in order to keep the business going.

Not only will small businesses see their taxes go up under the Reid bill, they will see their health insurance premiums go up as a result of new taxes on health care providers. Beginning in 2010—that is 3½ years before many of the health reforms go into effect—new fees will be imposed on health insurance companies. That is right now, 3½ years before the reforms go into effect. The Congressional Budget Office and the Joint Committee on Taxation have characterized these as excise taxes. They have also testified that these fees will be passed through to consumers in the form of higher premiums.

If you need prescription drugs, you get taxed. Beginning in 2010, new fees will be imposed on prescription drug manufacturers. Similar to the health insurer fee, CBO and Joint Tax say it will be more expensive to buy prescription drugs.

If you need a medical device, you get taxed. Medical device manufacturers will be subject to a 2½-percent excise tax on sales. Again, the Congressional Budget Office and Joint Tax have testified that this tax will increase the cost of medical devices. Just like prescription drug costs and health insurance, this new tax on devices will drive premiums up. If you have high out-of-pocket drug expenses, you will get taxed. A family will no longer be able to deduct medical expenses that exceed 7½ percent of their gross income as they can now. Instead, they can only deduct expenses that exceed 10 percent. In plain English, this proposal limits the tax deductions a family can take for medical expenses. For example, a family of four earning $57,000 in 2013 would lose a tax deduction of $1,425. A family of four earning $92,000 in 2013 would lose a tax deduction of $2,300.

Instead of working toward a bipartisan solution to our economic problems, Senator REID has brought a bill before us that spends $2.5 trillion over 10 years, raises taxes on middle-class families and small businesses. I support health care form, and I will continue to work to enact real reforms that lower the cost of health care. I cannot, however, support higher taxes that further jeopardize our economic recovery by punishing small businesses and raising health care costs for working families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. How much time do I have allotted? I thought there was an agreement that I had a certain amount of time.

The PRESIDING OFFICER. The minority side has 46 minutes 59 seconds, with the 10-minute time limit therein.

Mr. BROWNBACK. I yield myself 10 minutes to speak on the Dorgan amendment.

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

Mr. BROWNBACK. Mr. President, the Senator from North Dakota is a strong, good, talented legislator. He has a good amendment, one I have looked at. It has been around for a long time. I have to rise in opposition to it.

I am ranking member on the Appropriations Subcommittee on Agriculture, Rural Development, and the Food and Drug Administration. The FDA is in the purview of our subcommittee, so I work on the issues of the FDA. If I may brag, the University of Kansas is one of the best pharmaceutical schools in the world and is often rated No. 1 as a pharmacy school. For anybody interested in that field of study or work, it is a good place to go. They are very concerned about what is in the Dorgan amendment.

The United States currently has one of the safest drug supply systems in the world that allows the Federal Food and Drug Administration to monitor and regulate the manufacture and distribution of approved medicines. The legal authority to import drugs already exists in this country. However, no HHS Secretary, Democrat or Republican, has been able to certify that the importation of prescription drugs from foreign nations is safe or will lead to cost savings. None have been able to.

The Dorgan amendment will allow for the importation of drugs from outside our current regulatory system, established and enforced by the FDA without certification from the Secretary of HHS or the Food and Drug Administration. Allowing drug importation from foreign nations could threaten public health and result in unsafe, unapproved, and counterfeit drugs being placed on pharmacy shelves in the United States.

I want to develop that thought. The FDA has been tasked with the responsibility of safeguarding this country's prescription drug supply and has executed that responsibility quite well. But as this country and the Food and Drug Administration struggle to prevent the growing threat posed by imported, foreign-produced goods, as evidenced by recent failures to detect polluted products such as infant formula, pet food, and toothpaste, permitting the importation of drugs from foreign nations without the complete assurance from the FDA that it will not jeopardize public safety is irresponsible and threatens this Nation's safety and proven drug supply.

Toward that end, I ask unanimous consent that a letter that Senator CARPER received from the Health and Human Services agency, the FDA Director, be printed in the RECORD at the conclusion of my comments.

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

(See exhibit 1.)

Mr. BROWNBACK. This letter states in particular:

> We commend the sponsors for their efforts to include numerous protective measures in the bill that address the inherent risks of importing foreign products and other safety products relating to the distribution system of drugs within the U.S. However, as currently written, the resulting structure would be logistically challenging to implement and resource intensive. In addition, there are significant safety concerns related to allowing the importation of non-bioequivalent products, and safety issues related to confusion in distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

In other words, they don't think we can do this—importation, reimportation of drugs—without significant safety problems.

There has been an explosion of illegal drug counterfeiting occurring around the world. Emergence of a multibillion-dollar international black market has

proven to this Senate, current and past HHS Secretaries, and the FDA that weakening our prescription drug regulatory framework would only increase the risk of life-threatening counterfeit, contaminated, or diluted prescription drugs entering our prescription drug supply that millions of Americans rely on and trust. Prescription drug counterfeiting has become a highly profitable criminal enterprise that has been taken up by international organized crime syndicates, rogue nations such as North Korea, Syria and Iran, and developing nations such as China and Pakistan that seek to exploit ineffective or weak counterfeit enforcement frameworks around the globe.

Criminals have realized that the production of counterfeit drugs is twice as profitable as the trafficking of illegal narcotics and comes with significantly less criminal penalties compared to those handed out for illegal drugs.

Due to these limited and minimal criminal penalties, global counterfeiting has grown into an epidemic that reaches every country around the world. The World Health Organization estimates that tens of thousands of people are dying due to counterfeit HIV, diabetes, and tropical disease medicines. Unfortunately, in most counterfeit cases, it is not what is included in these fake drugs, it is what has been excluded that proves to be most harmful and deadly to patients. By taking counterfeit, diluted, or completely ineffective drugs, many patients fail to receive the important lifesaving medicines they need. It is just as dangerous for a person with high cholesterol to use a counterfeit drug that lacks the prescribed medicine as it is for a person to ingest a contaminated or even a poisonous pill. Due to this global counterfeit epidemic, two Secretaries of HHS, under both the Clinton and Bush administrations, have been unable to certify that the importation of prescription drugs will not pose a substantial risk to the health and safety of citizens within the United States.

Current Secretary Kathleen Sebelius, from Kansas, has committed to preventing a drug importation system in the United States until it can be proven that the safety standards of the imported drugs are ''at or above American standards.'' The FDA doesn't believe they can get that done at this time.

Many have argued that parallel trade in Europe has proven drug importation across nations' borders has resulted in prescription cost savings and has not increased risks to consumers or general public health. However, these cost and safety assertions do not correctly reflect the European experience with drug importation through what is called parallel trading.

A study by the London School of Economics on drug importation costs concluded that savings from parallel imports benefit middlemen and third-party vendors who buy and resell the imported drugs and do not get passed on to the patients in the form of lower prices. They say this:

> Although the overall number of parallel imports has continued to increase, healthcare stakeholders are realizing few of the expected savings . . . profits from parallel imports accrue mostly to the benefit of the third-party companies that buy and resell these medicines.

Furthermore, a report by the University of London School of Pharmacy on the safety of the parallel prescription drug trade stated this:

> The United Kingdom is the most vulnerable in Europe to counterfeiting owing to the high level of ''parallel importing.''

Due to parallel trade, the Medicines and Health Care Regulatory Agency in the UK has issued 10 different recalls of counterfeit drugs in the past 5 years. Drugs recalled include prescriptions to treat schizophrenia, blood pressure, and prostate cancer. The most disturbing fact of this counterfeit infiltration was that these drugs entered the United Kingdom through legitimate supply chains through parallel distribution trade, according to the MHRA, the regulator agency in the UK.

In other studies, the European Commission found that the prescription drug supply chain in Europe, which includes the former Eastern bloc counties such as Latvia, Slovakia, and Bulgaria, is increasingly targeted by international criminal counterfeiters.

The European Commission's Vice President, Gunter Verheugen, stated European parallel trade ''[B]rings a considerable risk for the safety of the patients'' and that the increase in counterfeit medicines ''is a very serious threat to public health and can cost lives.''

We don't want that happening to the United States, particularly with what we have seen in recent products coming in from China, not regulated under our system: things such as toothpaste, pet food, and then the problems we have here. Do we want that to happen in the drug system? No, we don't. We can't certify that we can keep these products safe.

As you can see, safety concerns and the lack of savings that may result from exposing this country to the potential risk created by the importation of drugs from outside our current safety system are real threats.

It is kind of interesting. In October 2004, then-Governor Rod Blagojevich of Illinois launched the I-SaveRx Program to allow residents in Illinois, and later Missouri, Vermont, Wisconsin, and Kansas, to purchase low-cost drugs from Canada. However, by 2006, the Illinois State auditor found that the program cost nearly $1 million and was used by only about 3,700 people in Illinois and 267 residents of my State of Kansas.

Health and Human Services has concerns regarding the safety of importation. The Food and Drug Administration has concerns regarding the safety of importation. Given the opportunity to purchase Canadian prescription drugs, only 267 Kansans took that chance. We should not throw out the safety of our drug supply chain without safety assurances from this country's regulatory bodies.

I yield the floor.

EXHIBIT 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES, FOOD AND DRUG ADMINISTRATION,

Silver Spring, MD December 8, 2009.

Hon. TOM CARPER,
U.S. Senate,
Washington, DC.

DEAR SENATOR CARPER: Thank you for your letter requesting our views on the amendment filed by Senator Dorgan to allow for the importation of prescription drugs. The Administration supports a program to allow Americans to buy safe and effective drugs from other countries and included $5 million in our FY 2010 budget request for the Food and Drug Administration (FDA or the Agency) to begin working with various stakeholders to develop policy options related to drug importation.

Importing non-FDA approved prescription drugs presents four potential risks to patients that must be addressed: (1) the drug may not be safe and effective because it was not subject to a rigorous regulatory review prior to approval; (2) the drug may not be a consistently made, high quality product because it was not manufactured in a facility that complies with appropriate good manufacturing practices; (3) the drug may not be substitutable with the FDA-approved product because of differences in composition or manufacturing; and (4) the drug may not be what it purports to be, because it has been contaminated or is a counterfeit due to inadequate safeguards in the supply chain.

In establishing an infrastructure for the importation of prescription drugs, there are two critical challenges in addressing these risks. First, FDA does not have clear authority over foreign supply chains. One reason the U.S. drug supply is one of the safest in the world is because it is a closed system under which all the participants are subject to FDA oversight and to strong penalties for failure to comply with U.S. law. Second, FDA review of both the drugs and the facilities would be very costly. FDA would have to review data to determine whether or not the non-FDA approved drug is safe, effective, and substitutable with the FDA-approved version. In addition, the FDA would need to review drug facilities to determine whether or not they manufacture high quality products consistently.

The Dorgan importation amendment seeks to address these risks. It would establish an infrastructure governing the importation of qualifying drugs that are different from U.S. label drugs, by registered importers and by individuals for their personal use. The amendment also sets out registration conditions for importers and exporters as well as inspection requirements and other regulatory compliance activities, among other provisions.

We commend the sponsors for their efforts to include numerous protective measures in the bill that address the inherent risks of importing foreign products and other safety concerns relating to the distribution system for drugs within the U.S. However, as currently written, the resulting structure would be logistically challenging to implement and resource intensive. In addition, there are significant safety concerns related to allowing the importation of non-bioequivalent products, and safety issues related to confusion in distribution and labeling of foreign products and the domestic product that remain to be fully addressed in the amendment.

We appreciate your strong leadership on this important issue and would look forward to working with you as we continue to explore policy options to develop an avenue for the importation of safe and effective prescription drugs from other countries.

Sincerely,

MARGARET A. HAMBURG,
Commissioner of Food and Drugs.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, this is the 10th day in the debate on health care reform. I believe it is one of the most important issues we have ever debated, certainly in my time on the floor of the Senate. There have been a variety of amendments offered, and there has been a lot of work going on off the Senate floor. Before we could reach this point and start this debate, committees held hearings that went on for weeks and months. They started with the base bill and entertained hundreds of amendments. The HELP Committee, as well as the Finance Committee, devoted so much time to this.

The first time I can recall the chairman of the Senate Finance Committee MAX BAUCUS coming to see me personally on this was over a year ago. So over a year has gone into this effort to come to this moment. I might add, the negotiations and efforts to improve the bill have not stopped. As late as last night, a large group of members of the Democratic caucus in the Senate were meeting to work out pretty contentious issues relating to competition for private health insurance companies. They worked late into the night, night after night, and finally came up with a consensus where differing points of view had to make concessions and come up with the best way to move forward. That is what has gone into the base bill that is before us.

This is it, 2,074 pages put together through all of the work I have just described. I understand the responsibility of the minority party in the Senate is to disagree. But we hope they will do it in a constructive fashion. In this situation, we have invited them in from the beginning. In fact, in each of the committees, Republican Senators have been active participants offering amendments, many of which were adopted.

Beyond that, there were meetings off the Senate floor. The Senator from Wyoming was a party to meetings that went on for, I am told, more than 60 days in an effort to find a bipartisan middle ground. But the fact is, we come here today in the Senate debating this bill, and there are several realities. The first reality is, after the House of Representatives went through a similar exercise, only one Republican Representative, a Congressman from New Orleans, LA, voted for health care reform, only one. In the Senate to date, only one Republican Senator, Senator SNOWE of Maine, has voted for health care reform in the Finance Committee. Not one single Republican Senator other than Senator SNOWE has voted to move forward on health care reform.

There is a second reality. There is no Republican health care reform bill. None. They have a variety of different ideas, but each one is discrete and specific. They are not comprehensive. They don't really address the issues this bill addresses. They have not presented a bill which makes health insurance premiums in America more affordable. This bill does.

Don't take a politician's word for it. The CBO looked at this bill and said it will bring down premiums for the vast majority of Americans paying for health insurance today, something we definitely need because we are dealing with a situation where individuals, families, and businesses can no longer afford health insurance. There has not been a bill produced on the other side of the aisle which guarantees that 94 percent of Americans will have health insurance. This bill does. They haven't produced that bill. When this bill is enacted into law, we will have a larger percentage of our American citizens covered with health insurance than ever in our history.

They have not produced a bill which changes the way health insurance is managed and its relationship with its customers across America. This bill does. There is a bill of rights in here that says: American consumer, you have a right to have health insurance, even if you have a preexisting condition. You have a right to stand up to the health insurance companies when they deny you coverage, saying: We only cover you when you are well, not when you are sick. You have a right for your children to be covered under your family health insurance policy until they reach the age of 27. These are rights which we guarantee in the bill and have not been brought to the floor by the Republican side because they do not have a health care reform bill.

Before us at this moment is a motion to commit by a friend of mine, Senator CRAPO, who raises a question about will there be taxes. Will people have to pay for what we are doing here? Well, I can tell you, we think we have struck a good balance in terms of shared responsibility. First and foremost, understand this: If we dropped this debate, as most Republicans would have us do at this moment, and walked away and said: We are not going to do anything, each and every American will continue to pay over $1,000 a year in added premium costs to cover the cost of uncompensated care.

In my hometown of Springfield, IL, we have some wonderful hospitals. When poor people with no insurance show up, they are treated, they are cared for. That hospital, then—whether it is St. John's or Memorial—has to pass along the cost of that health care to the other people who are paying for their care, which means each of us is paying $1,000 more a year for our families in health insurance premiums to cover those uninsured. So that $1,000 tax is already there.

Let me tell you what this bill does. This bill says, if you are making less than $80,000 a year, we will help you pay your health insurance premiums, give you tax breaks to pay those premiums. That means a lot of people who today cannot afford to pay for health insurance premiums will be able to. They will go to this exchange. They will be able to chose from health insurance options, and they will get a helping hand to pay for health insurance.

We also have special provisions in here to take care of the smaller businesses. If you have fewer than 25 employees and have a small business—and that represents a lot of businesses, mom-and-pop businesses, for example—we are going to give you a helping hand so you can pay for the health insurance coverage for yourself, the owner of the business, and the people who work for you.

What about those that are larger companies? Well, let's be honest about it. We expect them to step up and accept this shared responsibility. Most of these companies do not question whether they have to pay into unemployment insurance or workers' compensation. That is part of the cost of doing business. We are saying that in this era of health care reform, with shared responsibility, businesses should offer good health insurance for their employees. In most instances, they do, and they deserve our commendation for doing it.

But we also understand there are some that may not cover their employees, may have waiting periods that are unreasonable. We start moving our policy against that so people do have the peace of mind of knowing, when they go to work, they have good health insurance that is going to be there when they need it. It is a new look at it.

But we started with a real challenge. America is the only developed, industrialized country in the world where a person can die for lack of health insurance. We are the only one. There is not another country where that happens.

We are also the only developed country in the world where a person can be driven into bankruptcy because of medical bills. We kind of accept it. Well, so and so had an accident, went to the hospital, was there for a month, and has a huge medical bill. They did not have any savings or insurance, and it wiped them out. It wiped them out.

It does not happen in other countries. In developed countries, it does not happen because they take care of people, and they understand whether they are using private health insurance or public health insurance, there is a social obligation to make sure we all have the peace of mind of knowing that is not going to happen.

So we address this, and we help people pay for their premiums as well. There is $441 billion in tax relief in this bill for families over the next 10 years to pay their health insurance premiums. That is a tax break that will lead to more insurance coverage and more peace of mind. That is a reality. For the smaller businesses, with 25 and

fewer employees, there is a helping hand for them to cover their employees as well.

We also provide some competition that in many places does not exist today. We provide that there is going to be health insurance options for people. Too many small employers whom I have run into say: It is a take it or leave it deal with our health insurance company. We will renew last year's policy at a higher cost with less coverage, and you better take it because there is no place else to go. That is going to change here. That is part of the change.

For all my Republican friends and colleagues who have come to the floor over the last 10 days critical of this health care reform bill, I understand, that is part of Senate debate, that is part of what we are here for. But make no mistake, these same Senate Republicans do not have a health care reform bill. Most of the amendments that have been offered have been to protect health insurance companies, companies that are wildly profitable, companies that, frankly, dictate in this system how much people are going to pay and whether they are going to have coverage.

Dutifully, now, the Republican Senators have stepped up saying: We have to protect these health insurance companies and their profits. I do not think that is my responsibility. My responsibility is to almost 13 million people in my State of Illinois and to the rest of the Nation, to make sure they have the same peace of mind we all want—to know they have quality, affordable health care, to extend the reach of health care and the peace of mind that comes with it to the largest percentage of Americans in history.

The last point I wish to make is one about the deficit. We hear a lot about the deficit. This health care reform bill will cut more money from the deficit—$130 billion over the next 10 years—than any single bill ever considered on the floor of the Senate. Again, that is not my conclusion but the conclusion of the Congressional Budget Office, which analyzes these bills for Democrats and Republicans—a $130 billion reduction in the deficit over 10 years and, in the next 10 years, an additional $650 billion. Because as we start to bend the curve to bring down the increase in health care costs, it means we pay less for Medicare services, less for Medicaid services, less for many services that are offered through government programs.

This bill is fiscally responsible. President Obama challenged us to make it such, and we did it. There has not been a bill offered by the Senate Republicans which reduces the deficit—not anywhere near this amount. No one has ever done it. It took a lot of hard work to reach this point.

I would say the net result of the motion to commit by Senator CRAPO is, unfortunately, to delay this debate even further, to stop the momentum toward health care reform. I do not think that is what America wants or needs. This is a once-in-a-political-lifetime opportunity to address an issue on the mind of every American and to do it in a fair and comprehensive way.

Certainly, this bill is not perfect. As hard as we tried, it never will be. But to just continue to argue there are elements they want to question, without offering a comprehensive health care reform alternative, I do not believe is a fair debate. We have put the time into this. I stand by it. I will be proud to support it. There are things in it I do not agree with; most things I do. But the fact is, it is the right thing for us to do at this moment in history. We cannot miss this opportunity. I encourage my colleagues to oppose the Crapo motion to commit.

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

The PRESIDING OFFICER (Mr. SANDERS). Twenty-four minutes 40 seconds for the Democrats.

Mr. DURBIN. Mr. President, how long have I spoken?

The PRESIDING OFFICER. The Senator has spoken for 8 minutes.

Mr. DURBIN. Mr. President, I stand in support of the amendment that is being offered by the Senator from North Dakota, Mr. DORGAN. Senator DORGAN has talked about drug reimportation, and he has raised an issue which troubles me. Why is it that pharmaceutical companies in America charge Americans more for their product than they charge customers in other countries buying exactly the same product? Senator DORGAN had a hearing once, and the response was obvious. The pharmaceutical companies say: We charge Americans more because we can.

In all those other countries, such as Canada, when they try to sell drugs to Canadians, the Canadian Government steps in and says: You are entitled to a profit, but don't go overboard. We will allow you to increase your profits only so much each year.

In the United States, there is no such mechanism and no such effort. So we continue as a nation to pay premium prices for drugs that are exactly the same drugs that are sold at a fraction of the cost around the world.

The AARP, which is the largest organization of seniors in America, did a study of drug prices published in April. It showed that the price of the most commonly used drugs has risen faster than general inflation every year since 2004. This year, drug prices are going to go up another 9 percent, for example.

So a lot of Americans are saying: If I can buy the same drug in Mexico or Canada at a lower price, why wouldn't I be allowed to do that? Why would you stop me under the law? Well, I do not think we should. I think we ought to give people that opportunity.

What Senator DORGAN has done is to build in his amendment safety features so we know we are not dealing with counterfeit drugs and we know there is accountability as to the source and the purity and the effectiveness of the drugs that are bought.

This amendment creates a role for the Federal Government in providing oversight, with the goal of ensuring that Americans have access to lower prices and the peace of mind of knowing their drugs are safe.

The bill allows pharmacies and drug wholesalers licensed in the United States to import FDA-approved medications from Canada, Europe, Australia, New Zealand and Japan and pass along the savings to their American customers. What does it mean? A 35- to 55-percent lower cost for some of the most widely used drugs in America.

This approach will reduce costs when people need it, particularly sick people who are dependent on drugs to stay healthy or to avoid even further illness.

The CBO estimates that the new policy will result in Federal savings of $19.4 billion over 10 years. I will tell you why I think this is critically important. There are a lot of drugs and drug companies that are doing very well. They are very profitable, and they are based in the United States. I think it is unfair they are charging the people of their own country higher prices than they are charging people in other countries around the world.

This reimportation is an effort to try to help bring down some of these drug prices. These companies, incidentally, say: Well, we need the money because we need to do research for new drugs. Well, certainly they need to do research for new drugs. But maybe they can stop and explain to me or to someone why they spend more money on advertising than they do on research. You have seen the ads on television, heard them on the radio, and seen them in magazines. They spend a fortune advertising, trying to lure people into using the highest priced drugs in America.

These pharmaceutical companies are doing very well. Their profits are skyhigh, sometimes the highest in America. I think it is fair in this bill, as we try to bring down the cost of health care, that we also bring down the cost of these drugs by allowing the importation, with strict safety standards, of these drug into the United States.

I support the Dorgan amendment and look forward to making more affordable prescription drugs available across the United States.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAPO. Mr. President, I ask unanimous consent to speak for up to 20 minutes.

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

Mr. CRAPO. Thank you, Mr. President.

Before I begin my remarks, I would like to yield a couple minutes to my friend and colleague from Oklahoma who would like to respond to the question that has been raised as to whether

the Republicans are presenting reliable, meaningful, and comprehensive alternatives.

Mr. COBURN. I thank my colleague from Idaho.

Mr. President, the majority whip realizes there is an alternative bill. As a matter of fact, there are four alternative bills out there. They were not given a hearing. They did not have the resources. They did not have the CBO that would score them.

We have a bill that guarantees if you like what you have now, you can keep it; has absolutely zero tax increases on American families; no increases in taxes on American business; lowers the cost of everybody's health insurance premiums; covers preexisting conditions, period; protects seniors' high-quality care and choices; increases personal control over your own health care; no Medicaid expansion, but, in fact, puts Medicaid patients into true coverage without discrimination and allows all the doctors in this country to see them. It protects the physician-patient relationship and empowers patients, families, and physicians and providers. It does not empower the government. The majority whip knows that. Yet we have just heard on the floor we have not offered anything.

We have offered a bill that outside evaluators say saves the States at least $1 trillion in the first 10 years, saves the Federal Government $70 billion, treats everybody the same, creates access to health care, and, more importantly, it incentivizes prevention and the management of chronic disease and, finally, it attacks some of the $100 billion a year in fraud in Medicare and Medicaid, where this bill attacks less than $400 million a year in Medicare and Medicaid.

I yield back to the Senator.

Mr. CRAPO. I thank my friend from Oklahoma because it is frustrating sometimes to have it continuously said that there are no alternatives being put forward when we have for years promoted major and comprehensive alternatives to the kinds of issues Americans are asking us to address today.

What is it that Americans are asking? I have said this many times on the floor. Americans are asking us to find a pathway to lower health care premiums and costs and to increase access to better quality health care. Yet what is it that we are being faced with in this legislation? This bill drives up the cost of health care, not down, contrary to claims that have been made on the floor repeatedly; raises taxes by hundreds of billions of dollars; cuts Medicare by hundreds of billions of dollars; grows the government by $2.5 trillion; forces the needy uninsured—it doesn't give them a pathway toward subsidized insurance or any access to insurance but instead forces them into a failing Medicaid Program; imposes damaging unfunded mandates on the struggling States; leaves millions of Americans still uninsured; and establishes massive government controls over our health care economy. And we wonder why we cannot get engaged in a meaningful bipartisan solution here with this kind of heavy-handed approach being insisted upon.

When I talk about the fact that it raises the costs or the size of government, often the response is: No, this bill doesn't raise the size of government, it doesn't increase the size of government, it is balanced. Actually, CBO has issued a report that says it reduces the deficit. Well, the fact is it grows the size of government over a true 10-year period by $2.5 trillion. It does provide some increased taxes—a lot—and it does cut Medicare. By doing so, it does reach an equilibrium, according to CBO, with regard to its impact on the deficit. But let's not mistake this deficit with the size of the government. This bill will grow the size of the government and the reach of the government by $2.5 trillion.

With regard to the question as to whether it truly impacts the deficit, I think most Americans have already heard that there are some budget gimmicks here. You could not ever claim this bill doesn't increase the deficit unless you had all the taxes I am going to talk about in a minute and unless you had all of the Medicare cuts we have been talking about for the last week, and unless you had the budget gimmicks that are in the bill. The budget gimmicks are clearly depicted right here.

Look at the first 4 years of this bill on the spending side: very little, if any, spending. The actual implementation of the spending part of the bill doesn't happen until 2014, but all the taxes start in the first year, and all the Medicare cuts come into place in the first year, and we start seeing the offset side of the bill run for a full 10 years. It is going to be easy to say you have balanced out spending and taxing if you don't count the spending for the first 4 years. But if you look at that first true 10-year period of time, it is a growth of the government by $2.5 trillion.

What I am here today to talk about is my motion that is on the floor to do one very simple thing: to commit this bill back to the Finance Committee and have the Finance Committee make the bill comply with the President's pledge to the American people about taxes. And what was his pledge, repeated many times across this country? In the President's own words:

> I can make a firm pledge . . . no family making less than $250,000 will see their taxes increase . . . not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes . . . you will not see any of your taxes increase one single dime.

That was the rhetoric. That was the pledge. What is the reality of the bill? In its first 10 years, the bill raises taxes by $495 billion. If you take that 10-year window that starts in 2014 where you are comparing spending and taxing at the same time, the total of taxes in that 10-year window is $1.2 trillion of new taxes, a huge proportion of which falls squarely on the backs of the middle class whom President Obama has defined here to be those earning less than $250,000, and that is per family. He said under $200,000 per individual.

What are some of these taxes we are talking about? First, there is the excise tax on high-cost premium plans. One might say, wait a minute, that is a tax on companies, employers who provide very high quality insurance to their employees. It is an ingenious way—it is technically written that way—but it is an ingenious way to actually increase the cost, the tax base, of the workers and not the employer. Let's see the first chart. The way this works is the government will now say to an employer: You cannot provide health insurance to your employees that is worth more than a certain amount. Most employees who get health insurance—and that is most employees in the country who get health insurance from their employer—get wages and health care as a part of their total employment package.

I picked an example of a woman who receives $50,000 in wages and let's assume a $10,000 employer-provided health care benefit. The government is now going to say wait a minute, to her employer; we are going to tax you if you provide that health care benefit on such a robust level. CBO and Joint Tax have told us that the reaction of the vast majority of all employers is going to be to reduce the health care benefit down below the level that gets taxed. They are not going to reduce the employee's overall benefit, however, their overall employment package. So let's pick a number. Let's say they reduce this $10,000 down to $7,000. They will increase the wages by $3,000 and the employee's total compensation package stays the same: $60,000, with one difference. Now that extra $3,000 is wages instead of health care, and it gets taxed. And that way the individuals in this country see their health care values go down. Their total compensation package stays the same, but then gets also reduced as it is taxed, and our Joint Tax Committee and CBO have told us that 84 percent of this $149 billion new tax is going to be borne by those with incomes under $200,000.

That is one way this bill ingeniously gets at the pocketbook of those making less money than the $200,000 or $250,000 as a family that the President talks about.

What is the next way? Medical deductions. I think everybody in America who itemizes deductions knows about the first line that says you can itemize your medical expenses, and to the extent they exceed 7.5 percent, you can deduct those medical expenses. So people who have a large proportion of their income represented by medical costs get a break in the Tax Code for that deduction. Well, that break is now going to be smaller under this bill because the level of where you are able to

get it is no longer going to be 7.5 percent, it will be 10 percent. And as I indicated, that 84 percent of the excise tax is going to fall on people making less than $200,000 a year. Ninety-nine percent of the medical deduction restriction will fall on people making less than $200,000 a year; as a matter of fact, making a lot less than $200,000 per year.

Then what about the next one? The next major tax in the bill is the Medicare payroll tax. This one has been presented to the American public as a tax on rich people. It starts out primarily impacting people at the higher levels, but at the outset, it will already hit 345,000 Americans, and it is not adjusted—I think most people understand how the alternative minimum tax works today. It is not adjusted for inflation properly. So over time, the payroll tax itself is going to increasingly hit more and more people in that income category under $200,000.

There has been some analysis on these three provisions in the bill. Joint Tax has indicated that by the year 2019, at least—and I say at least because we are only talking about three provisions in this bill right now, and there are more—73 million American households—not individuals, households—73 million American households earning below $200,000 that are going to face a tax increase.

Some have responded to this by saying, Wait a minute. Our bill actually cuts taxes and you are not characterizing this fairly. The tax cuts they are talking about are primarily a $394 billion government subsidy for purchase of health insurance, a subsidy that will be administered through the Tax Code. What they don't tell you is that $288,000 of this so-called tax cut is nothing other than a direct government payment to those who don't pay any taxes today anyway. It is not reducing their tax liability; they have no tax liability. It is a direct government subsidy, and CBO says so. It is scored by CBO not as tax relief; it is scored by CBO as direct government spending. To characterize that as tax relief I believe is inaccurate.

Moreover, even if it were true tax relief, is that what the President was saying, that I won't raise your taxes more than I will lower someone else's or was he saying to the American people that he would not raise taxes on people who are making less than $200,000 a year, or $250,000 as a family? I believe it is inherently obvious what the President was saying. And to say now that we are cutting somebody else's taxes so we can raise yours does not comply with the President's pledge.

To give another couple of perspectives on this in terms of numbers, when all is said and done, 7 percent of Americans will get this so-called tax relief that is, in reality, direct Federal spending, and the rest of Americans—specifically, those who don't fall in that category—will get the tax increases. Out of 282 million Americans with some kind of health insurance today, only 19 million of them will be helped by this subsidy. The rest are going to fall into that category of those who get to share in the burden by seeing their taxes increase.

But let's say we give credit for all of these arguments and say, All right, we will let you claim that all of this spending is tax relief. What is the true story then? Even if you give that argument, which is not valid, by 2019, there will still be at least 42 million American households earning below $200,000 that will face a tax increase. This is information from the Joint Committee on Taxation.

In fact, the data there is rather interesting. Joint Tax data indicates that by 2019, individuals earning between $50,000 and $200,000 on average will see an increase in their taxes of $593. Families earning between $75,000 and $200,000 will see on average a net tax increase of $670.

So what does my amendment do? My amendment says very simply that the bill will be committed back to the Finance Committee and that the provisions in the bill that violate the President's pledge should be removed. Simply make the bill comply with the President's pledge. The President, frankly, shouldn't sign this bill unless this amendment is passed and implemented, because that is the direction we need to go.

Once again, the President's pledge is that no family making less than $250,000 is going to see their taxes increased.

There is further information available about this, though. I recently sent a letter to the Joint Tax Committee. I recently sent a letter to the Joint Tax Committee asking them about whether there were other provisions in the bill other than these three—the reason I talked about these three taxes is because those three taxes have been analyzed by Joint Tax and it is Joint Tax that is telling us what they are going to do.

In response to my letter saying are there more taxes in the bill than those you have analyzed, the answer has come back, yes, and below, they say, is a list of the provisions that they have not previously distributed and that have statutory incidence on individuals with those who fall below the income threshold which has been defined already. What are these taxes? There is a confirmed definition of medical expenses for health savings accounts. In other words, the reduction of benefits in health savings accounts will have an impact, and I believe that impact is about $1.5 billion.

The increased penalty for nonqualified health savings account distributions and limitations on flexible spending arrangements will raise almost $15 billion. Most of this—although we don't have the data yet from Joint Tax—most of this comes from families below the income tax threshold, as well as the 5 percent excise tax on cosmetic surgery and similar procedures and the individual mandate in the bill that will force all Americans to purchase insurance or the IRS will come and collect a fee from them.

I don't have the chart here that shows what will happen with the IRS, but think for a minute. The current size of the IRS is about $12 billion in terms of the appropriations we give them to perform their functions. CBO says that if this bill passes, there will be so much additional business for the IRS in monitoring health care and the new plans and programs in the bill, there will have to be at least another $5 billion and maybe a $10 billion increase in the size of the IRS just so it can implement its enforcement responsibilities under this bill.

The bottom line is that the President of the United States, Barack Obama, has made a pledge. It was that pledge, among a number of others—such as ''if you like what you have, you can keep it''—that caused us to see a strong low-confidence level by the American people, and maybe it is time for Congress to truly dig in and build a strong health care reform package. That pledge is being squarely broken by this bill.

Again, all we are asking in this amendment is to send the bill back to the Finance Committee and have the Finance Committee make the bill conform to the President's pledge. What that will mean to the American people is that in the first 10 years of the bill, just under $500 billion of new taxes will not be imposed, and over the true first 10-year period, when the spending starts kicking in, $1.2 trillion worth of taxes will not be imposed.

There are many other issues with this bill that we have seen discussed. There is the question of whether it truly increases the cost of premiums in health care. Virtually 10 out of 11 studies say that it does. The CBO report says that, clearly, for 30 percent of Americans, it does it in major ways, and for the other 60 percent, the impact is marginal, or the status quo.

As we move forward, some of these big problems with the bill need to be fixed. My motion focuses on taxes. We have debated Medicare for some time now. We need to talk about the unfunded mandates on the States. We need to talk about the impact on premiums in health care because we don't want to be passing legislation that drives up the cost of health care at a time when that is the primary purpose for people calling for health care reform.

I urge my colleagues to let us step down for a moment from the intensity of the debate, commit this bill to the Finance Committee, and let's, on a bipartisan basis, work out some of the solutions to these problems and do so in a way that does not result in such a massive growth of our Federal Government, such a massive increase in taxes, such a massive unfunded deficit on the

States, and all for no control of cost or health care premiums.

With that, I yield back the remainder of the time I requested.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, here we go again. We keep hearing it, and the other side keeps using scare tactics. All those Democrats say is tax, tax, tax. Scare tactics. They think they can scare people into believing something that is not true. The fact is, not only does this bill not raise taxes on the middle class, this bill is a tax cut for Americans.

Look at the chart behind me, which shows that. This is individual taxes. We are talking about taxes on individuals in America. This chart shows that in the year 2015, there will be a net tax cut for Americans of $26.8 billion—a tax cut. The other side says some of those folks are not paying taxes. That is true. It is a refundable tax credit of about $27 billion. In 2017, it is a net tax cut of $40 billion. In 2019, it is a net tax cut of almost $41 billion.

Nobody can read the small print on the chart, so I will read it:

Combined effects of the high-premium excise tax, health care affordability tax credits, increase in HI tax, increase in HI floor for medical expense deductions.

It is the basic provisions.

It is very important to point out that this is a net tax cut for most Americans. For some, there is a tax increase. But guess what. According to CBO, that is because those folks will make more money. Their wages and salaries will go up.

I don't see a chart-meister behind me to change the charts, but the chart shows almost for every year about a 10-percent increase in taxes for upper income areas and about an 80-percent increase in wages or income. That is basically because, according to the CBO, the high-premium excise tax will result. People will be paying lower premiums, 7 to 12 percent lower premiums as a consequence of the Cadillac tax provision. CBO says that; it is not my prediction. That will be passed on in the form of higher wages and higher income to people. People will be paying higher taxes, but they will be making more money.

Let's make it clear. This bill lowers taxes. At least that is what CBO says. It is one thing to make an allegation that it increases taxes, but CBO says there is a net tax cut, which I mentioned.

Turning to another subject—small business—one of the goals of health care reform, clearly, is to ensure employees and small businesses have access to quality, affordable health care options. Small businesses have a tough time providing health insurance, that is true. Last year, only 62 percent of small businesses offered health insurance to their employees. Compare that with about 99 percent of companies with 200 or more employees. Big businesses offer health insurance, but small businesses just can't do it. They have a hard time. Among the very small businesses, fewer than half offered their employees health insurance.

Small businesses say the main reason they cannot provide health insurance is because premiums are so high. That is probably true; it is expensive. I have talked to many small businesspeople, and I am quite certain the Senator from Vermont, who is in the chair, has run across the same comments from businesses. It is just too expensive.

In the past 10 years, premiums have risen 82 percent for single workers and 93 percent for families employed by small businesses. As health care costs rise, small businesses are forced to make workers pay a greater portion of these expensive premiums. Last year, employees in small businesses that provided health insurance paid more than twice what they paid in 1999. So in a period of 8 years, the amount employees paid more than doubled.

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

That is why the health care bill before us today includes provisions to make quality coverage more affordable for small businesses and their employees. The bill includes $24 billion in tax credits to help small businesses and charitable organizations purchase health insurance for their employees—$24 billion.

Starting in a couple of years, eligible small businesses would receive tax credits worth up to 35 percent of the employer's contribution to employee health insurance plans. Then in 2014, eligible small businesses will receive tax credits worth up to 50 percent of the employer's contribution to employee health insurance plans purchased in health insurance exchanges. That is half of the cost to the employer. An employer could take half of that cost as a tax credit against that company's income.

To qualify for the tax credits, businesses would have to cover at least half of their employee premium costs. The value of the tax credit is based on the size of the business and the average wage of its employees.

The small business tax credit will help make health insurance more affordable for many small businesses. That is clear. In 2011, 4.2 million Americans will be covered by quality, affordable health insurance because of this credit. On average, small businesses across the country will receive a new tax credit of around $5,000 to help them purchase insurance. The CBO has estimated that the small business credit will help lower insurance costs by 8 to 11 percent for employees at small businesses who receive that credit. CBO says, again, that small business credit will help lower insurance costs by 8 to 11 percent for employees of small businesses who receive the credit.

One of the reasons many small businesses are currently unable to afford health insurance is because they lack the buying power larger companies have to negotiate group rates. Our bill creates small business insurance exchanges, known as shop exchanges, where small businesses can join together and pool their risks. That will enhance their choice and buying power. These State-based exchanges will be a critical tool to help small businesses with fewer than 100 employees shop for health insurance plans and determine their eligibility for tax credits to buy health insurance. Small businesses that prosper and grow beyond 100 employees will be allowed to continue shopping in the exchanges.

The insurance plans sold in these exchanges will be subject to the same transparency requirements and consumer protections, so small businesses can feel confident they are purchasing high-quality plans that will provide quality, affordable coverage for their workers.

One more point. We all talk to small businesspeople. Time and time again, they say they like to provide health insurance. But what happens? The insurance company comes along and says: Next year, we are going to raise your premiums 20, 30, 40 percent. Why? The answer is that we found out one of your employees has a preexisting condition, so we are going to raise your premiums by that much. It puts small businessmen in a terrible dilemma: they either have to fire that employee to get the lower increase in premiums or eat that big increase and keep that employee.

I remember a businessman in Billings, a small contractor, whose heart sank when he got that notice from the insurance company. He decided to keep the valuable employee, who had worked for him for a good period of time. He will not fire that employee. He shopped around and finally found another insurance company, and the increase was not 30 percent, it was more in the nature of 20 percent.

Small businesspeople face this great variety of premiums. They go up this much and that much. It is because of the terrible situation we have where companies can deny coverage based on preexisting conditions, health care status, and so forth. Different States have different rating rules and so on. This will help small businesses get more stability and quality.

The insurance plans sold will be subject to the same transparency requirements and consumer protection that other individuals will also find available.

The health care reform bill before us also institutes reforms of the insurance market that will protect individuals and small businesses purchasing plans. I already mentioned that. These reforms will stop insurance companies from denying coverage based on preexisting conditions.

Passing health care reform is critical to small businesses. Without reform, many small businesses will be forced to drop their health care insurance coverage because they will no longer be

able to afford the increasing premiums. That would leave employees to fend for themselves in the individual market.

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

I ask unanimous consent to extend the period for debate only until 4:30, with the time equally divided, with Senators permitted to speak therein for up to 10 minutes each, with no amendments in order during that time.

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

The Senator from Maine is recognized.

Ms. SNOWE. Mr. President, I ask unanimous consent to speak for up to 20 minutes.

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

Ms. SNOWE. Mr. President, today the Senate is addressing the future of health care in our Nation—both Americans' access to care and its cost. As we confront projections of escalating health spending—exceeding $33 trillion in the coming decade—the imperative is clear that we must address rising costs, or affordable access to coverage simply cannot be achieved and sustained.

That is why I am joining Senator DORGAN, who has been a relentless champion on the issue of drug reimportation, in proposing the amendment to this legislation, so that Americans can safely and affordably access the medications which they rely upon to improve their health and which the industry has reminded us time and again are critical to reducing severe illness and hospitalization and, of course, extending life.

Senator DORGAN has long been the Senate's tireless leader. In fact, it has been more than a decade, as I recall, that he began to pursue this endeavor and this journey in seeking to end the inequity which resulted when Americans were barred from importing less expensive medications. He has reminded us regularly of the trade inequity which has been imposed on consumers. He also has reminded his colleagues that drug importation, conducted with proper safety measures, provides a route to improving access to lifesaving medications.

I am pleased to have joined him in this effort, once again, along with Senator MCCAIN, who has been a stalwart on this issue from the very outset and a tremendous advocate and a driving force. Of course, the Presiding Officer, the Senator from Vermont, Mr. SANDERS, throughout his career has been pursuing and advocating this inequity to be remedied once and for all.

We introduced this legislation back in 2003 for the very first time. We worked on a comprehensive approach required to address the safe, economical importation of medications. I well recall the efforts—the yeoman efforts—of the late Senator Kennedy who worked relentlessly to remedy this flaw in our policy, along with Senator GRASSLEY, Senator STABENOW, and Senator VITTER, whose bipartisanship on this vital question has also been instrumental as we advanced this cause for the better part of a decade. It has been a greater undertaking than I think many would have surmised or anticipated, frankly.

There can be little doubt that the effort to reduce health costs poses one of the greatest challenges in health care reform. That is why the Senate Finance Committee, under the leadership of Chairman BAUCUS, has worked mightily to incorporate provisions in the pending legislation to ''bend the cost curve.'' Let there be no mistake, the resistance to reforming spending has been immense. That is in part because, as so often has been said: ''One man's waste is another man's profit.'' So while other nations pay 35 to 55 percent less for their prescription drugs than the United States, we have continued to pay the world's highest prices for brand drugs for the past decade, despite nearly 10 years of effort to provide for the safe importation of prescription drugs.

Fortunately, that has not deterred a broad bipartisan call to arms on this issue, despite the industry's actions that have blocked attempt after attempt to provide Americans both access and assurances that imported drugs would be safe. Indeed, this issue of both safety and affordability has drawn a bipartisan coalition which has been a model for how we can work together to address this health care problem.

We created legislation which the Congressional Budget Office previously estimated would save our Nation approximately $50 billion over 10 years. The CBO has not yet estimated the total savings to consumers but has projected a savings to the Federal Government alone of $19.4 billion. Since Federal savings was about 20 percent of total savings in the past, one can hypothesize dramatically increased consumer savings likely approaching $80 billion. These are exactly, precisely the kinds of savings we must advance today.

One can easily see that the failure to act on this legislation since its introduction in April 2004 has needlessly carried a high cost for the American people, made all the more egregious and unacceptable given these difficult economic times, as more Americans are reducing or skipping doses or forgoing medication altogether. And this problem is not going to get better. It is regrettably only going to get worse.

The trend is undeniable and unabated. We are all painfully aware of the price increases in brand-name prescription drugs this year that bear absolutely no relationship whatsoever to our overall economy. Manufacturers have increased prices of brand drugs by an average of 9 percent, just as inflation measured by the CPI actually fell by nearly 1 percent.

We can look at this chart and demonstrate the contrast in increases. Brand drugs increasing 9 percent, and here are generics and here is the CPI. It truly is emblematic and reflective on this chart how actually prices have been decreased by the same amount that brand drug prices have escalated.

In other words, just as we are working to expand coverage to tens of millions of more Americans, we have the industry establishing a new pricing baseline that is entirely off kilter with the rest of the economy, in comparison between the CPI and the cost of brand-name drugs. It is widely unaffordable for the American people and clearly unsustainable for the future. How can we possibly not act on this amendment?

This is an industry that has offered $80 billion in concessions toward health care reform—approximately $8 billion over the next 10 years. When one considers that our annual spending, while this single price increase of 9 percent imposed over $290 billion in drug spending, with over two-thirds of that amount representing brand drugs, it is clear that this single price increase alone at this 9 percent will yield at least twice as much as the industry has pledged to reform in the pending health care reform legislation.

Frankly, that is cost shifting of the worst kind because it occurs on the back of the American taxpayer, most especially on those in greatest need who are also the least able to afford these exorbitant prices. There should be no mistake, these most recent increases are following the patterns we have witnessed year after year.

How do we know? Following passage of the Medicare Modernization Act, Senator WYDEN and I requested that the GAO track drug price trends, including looking back to before the bill was enacted.

What did we find? First, that the price of brand drugs has escalated two to three times the rate of inflation. That means $100 in drug costs in 2004 has grown to more than $140 today.

Tell me whose income has increased by that amount in the last 5 years alone. These unabated, escalating costs for drugs are only widening the already yawning gulf of unaffordability for the American people.

But that is not all. When Senator WYDEN and I examined the GAO data, we also discovered that as we neared the achievement of a prescription drug benefit under Medicare, the rate of price increases actually rose faster. History also appears to be repeating itself once again to the everlasting detriment of all those whose health security depends on medications.

One year ago, the Associated Press reported a startling find that for the

first time in a decade, prescription drug use was down. Given the rising costs imposed on struggling American families, that should come as no surprise.

It also should serve as a wake-up call, an alarm bell. We are long past the point where we should heed Einstein's timeless truism that one should not keep doing the same thing over and over and expect a new result. The fact is, we simply cannot assume pledges of savings in the form of the industry's monetary concessions to health reform actually amount to real, fundamental reforms or that drug assistance programs are a substitute for a market which brings consumers better value. They are not.

It is clear that the time for enactment of this legislation is long overdue and, frankly, more urgent than ever, as illustrated by this second chart of unfilled prescription drugs. Just looking at it, you can see how the unmet need for medications has actually increased since 2003. Among working age adults, only those with Medicare coverage experienced any improvement in their ability to fill their prescriptions. All others saw a rise in their inability to obtain the necessary medications.

Among the uninsured, more than one in three individuals went without a required prescription. And in those with chronic diseases, that number doubles. This is a travesty. Indisputably, despite manufacturer assistance programs, despite the increased use of generics, the high and escalating cost of brand-name drugs is directly and negatively affecting the health of millions.

That is why our voices today echo those of an overwhelming 7 out of 10 Americans who have called for lifting the ban on prescription drug importation. Let there be no doubt, this is a mandate for action. The President has added his voice to ours, calling for safe drug importation as one means to address health care costs which threaten the health of Americans in perilous economic times.

The bottom line is, when nations institute safe, regulated trade in pharmaceuticals, they achieve results, as Sweden did when it entered the European system of trade and saw a reduction of 12 to 19 percent in the price of traded drugs.

Opponents claim importation will cause American consumers harm. For those who did express concern about safety, no one shares that sentiment more than I do. So let me be unequivocal in stating that safety is the foundation of this legislation.

Our constituents have taken action repeatedly to purchase drugs which they could afford mostly in Canada. That is certainly true in my State of Maine. It is true in the State of Vermont, the Presiding Officer's State. It has been demonstrated time and again that importation is safe. We can ensure Americans safe access to imports. In Europe, over 30 years of parallel trading of pharmaceuticals has demonstrated indisputable safety. In fact, a former Pfizer executive, Dr. Peter Rost, has stated from his firsthand experience in Europe:

I think it is outright derogatory to claim that Americans would not be able to handle reimportation of drugs, when the rest of the world can do this.

Yet some will point to a recent FDA letter cautioning that drugs must be demonstrated to be safe and effective, that they must be manufactured under the highest standards, that an imported drug must be demonstrated equivalent to existing products used domestically, and that we must guard against contaminated and counterfeit drugs. This amendment does each of these things and much more to ensure that Americans can safely have access to safe imports.

Under this legislation, we see with this next chart, we would import drugs from 31 countries which meet high regulatory standards. Those are shown in blue on this chart. There are nations which meet our high standards. In most cases, individuals will purchase an imported prescription drug from their local pharmacists. Pharmacies will receive these drugs from U.S. wholesalers which import them. These wholesalers will be registered, inspected, monitored by the FDA. This higher level of safety is a first step in establishing a higher standard in the handling of prescription drugs in the United States.

Our legislation also allows individuals to directly order medications from outside the United States when using an FDA-registered and approved Canadian pharmacy. Again, just as with wholesalers handling prescription drugs, the FDA will examine, register, and inspect these facilities on a frequent basis. FDA will assure the highest standard for such essential functions as recording medical history, verifying prescriptions, and tracking shipments. Regardless of whether the purchase is from the local pharmacist or a Canadian pharmacy, we assure that a legitimate prescription and a qualified pharmacist are required to help assure safety.

For those who say that consumers could unwittingly purchase an unapproved or suspect drug, our legislation assures that drugs received will always be FDA approved. If any difference exists in a foreign drug—even the most trivial of distinctions—our legislation assures FDA will evaluate the product and determine its acceptability.

For those who say counterfeiting is a threat, our legislation requires the use of anticounterfeiting technologies to protect drugs. Today we can thwart counterfeiting by employing technologies like the one now used on $20 bills. Our bill not only requires the use of such counterfeit-resistant technologies but also a standardized numerical identifier unique to each package of a drug. Moreover, this bill supports the development of future anticounterfeiting and track-and-trace technologies which we hope will be used to protect all drugs.

For those who say the consumers won't know who has handled an imported prescription drug, our bill requires a chain of custody—otherwise known as a pedigree—be maintained and inspected to help ensure the integrity of imported drugs. A pedigree for medications was mandated by law in 1988 and has still not been implemented. This bill will change that.

For the first time, in fact, this legislation will include resources to inspect all facilities handling medications. So we are not just making imported drugs safer but also domestic drugs.

Some attempt to alarm Americans about the countries from which we would import drugs, citing nations such as Latvia, Estonia, Slovakia. The last time I checked, these are members of the European Union. The same is true for Ireland, for example, where Lipitor is made.

So let me get this straight: It is fine for those countries to manufacture drugs in their plants for domestic U.S. companies and ship those drugs here where we then have the privilege of paying higher prices than anywhere else in the world, but we somehow cannot safely import drugs made in those same countries. Exactly what kind of sense does that make?

In fact, going back to this chart where the European Union and other countries from which we would import appear in blue. So all those countries that are in blue are areas in which this amendment would allow the importation of drugs, which we see infrequent FDA inspections are in these red countries. All of these countries that are designated in red are the ones in which we have manufacturers importing ingredients for the final product. Yet there are infrequent FDA inspections. There are plants right now—today—shown on the chart in red that are making drugs that are sold and consumed in the United States, plants where there are few FDA inspections. In fact, it has been estimated that approximately 40 percent of the active ingredients in prescription drugs consumed in the United States are actually made in India and China, and we know oversight there is lacking. In fact, such plants may be inspected as infrequently as every 12 years.

Currently, there are more than 3,200 foreign manufacturing plants that make medications for the United States market according to GAO. The GAO also found that FDA, in the words of an Associated Press article on the matter, ''isn't even sure how many foreign facilities are producing for the American market. One government database suggests it's 6,760. Another says about 3,000.''

With the explosion of drugs coming in from nations such as India and China, as reported in the Washington Post, the FDA's ''budget for foreign inspections has not kept pace,'' and as a

result, as of 2007, ''foreign drug and drug ingredient makers are inspected on average once every eight to 12 years, while American-based manufacturers must be inspected at least once every two years.''

The article also reported that China itself has more than 700 plants, but the FDA only has the resources to conduct about 20 inspections a year there.

So let me just indicate, on this chart again, that we, under this amendment that is pending before the Senate, would allow drugs to be imported from those countries designated in blue. The countries that are designated and reflected in red are those countries where we currently manufacture the ingredients of the final product. We are not suggesting that drugs be imported from these nations. Yet our legislation will make it safer because of the resources that we have incorporated in this legislation before the Senate and all of the standards that will be required for FDA to inspect these facilities that are currently not inspected.

We have seen the dangers in ignoring these problems, and that is why this legislation would fund enhanced FDA foreign inspections to fundamentally improve the safety of drugs consumed in the United States. But that is not all. While opponents will cite current law on drug importation, the fact is, in the Medicare Modernization Act—the current drug importation statute which has never been implemented—there are just six safety provisions over as many pages—as detailed in this chart—versus the 31 major provisions in our amendment.

So when we passed the Medicare Modernization Act back in 2003, we included safety features because we heard from many of our colleagues who simply did not want to have drug importation. They claimed we had to have a safety certification process, which we have had numerous times for the last decade, to which nothing has advanced with respect to importation. Obviously, a safety certification hasn't been made because we haven't given any resources. We haven't implemented that certification in good faith.

Under the pending amendment, we incorporate 31 major provisions in our legislation to address each and every issue. We systematically analyze and identify every issue that has been raised by the opponents to the drug importation legislation—every safety-related issue, every standard-related issue, every failure that has occurred with respect to the FDA inspection system on where they are importing drugs currently and where they have not inspected those facilities. We have 31 different provisions in order to address every facet of safety-related issues.

So for those who say importation isn't safe, we show that it shall be. This legislation will set a model and a mandate for improving safety in the handling of not only imported prescription drugs but of all medications—even domestic ones.

But if that is not enough, let me also suggest to the opponents of this legislation that they are failing to observe the greatest safety threat to Americans—that the inability to take a drug as it is prescribed undoubtedly exacts a toll on thousands of American lives every year.

So beyond question, our measure addresses the crucial issue of safety. I think it is certainly indicative and reflective in this chart today, all the provisions that have been incorporated in the pending amendment before the Senate. This clearly will deliver the real savings as well as safety for consumers.

Organizations across the board are supporting this legislation. They represent more than 50 million Americans who realize that extending this coverage is fundamentally critically important to the well-being of all Americans.

The PRESIDING OFFICER (Ms. STABENOW). The Senator's time has expired.

Ms. SNOWE. I thank the Chair.

The PRESIDING OFFICER. The distinguished Senator from Montana.

Mr. BAUCUS. Madam President, I believe we have to amend the previous order which restricted speakers to 10 minutes. So I ask unanimous consent that the previous order be changed so that Senators may speak for longer than 10 minutes, and I yield 15 minutes to the Senator from New Jersey.

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

The Senator from New Jersey is recognized.

Mr. MENENDEZ. I thank the distinguished chairman of the Senate Finance Committee for yielding me the time.

Madam President, I rise in strong opposition to the Dorgan amendment to allow the importation of drugs from 32 different countries in the world into the medicine cabinets of American families. I believe that is, at its core, a regressive amendment.

This amendment, however well-intentioned, reminds me of a time when the lack of sufficient regulation allowed people to sell snake oil and magic elixirs. Let's not relive that history. Let's learn from it.

I am sure many in this Chamber remember a time when the doctor would give us a prescription, we would take that to the local pharmacy, and the one thing we never did was question what was in the bottle. Now, with this amendment, we would not be so certain. We would not be sure that what is in the bottle is what we think it is. We would not be so certain from where it came. It could be directly from countries all over the world—Lithuania, Estonia, Latvia, the Czech Republic, or any 1 of 28 other countries, and I will speak to that. Yes, I have heard they are part of the European Union, but I will talk about what the European Union just said about their challenges with counterfeit drugs. Or maybe they will come indirectly from any number of countries that have proven to make tainted medicine; those who are not part of the European Union but who are counterfeiting their drugs into the European Union, getting into their supply chain and ultimately getting to us, if we were to allow it to happen. We would not be absolutely sure of the conditions under which they were manufactured, whether they are safe to use, or where their ingredients originated.

Health care reform and lowering costs does not mean we should roll the dice with the health and safety of the American people.

I appreciate my colleagues' interest in bringing lower cost drugs to the market. In fact, I agree with them. But we cannot risk the health and safety of the American people in order to do it, and I am afraid this amendment would do just that.

We have heard a lot about the FDA—the Food and Drug Administration. Yes, they are the ones who safeguard Americans from having the wrong type of drugs get into our marketplace or making sure the right type of drugs are approved and the wrong ones stay out. I have heard the stories of Americans searching for affordable prescription drugs and either going online to get them or traveling sometimes. But we have to ensure the drugs they buy are not counterfeit, not tainted, not substandard, and that they are what the doctor ordered and will work.

This amendment would undo current safety protections that ensure that patients are getting prescription medications that are the same in substance, quality, and quantity their doctor has prescribed. So let's see what the FDA said.

In a letter from the Food and Drug Administration issued the other day to one of our colleagues in the Senate, Commissioner Hamburg said there are four potential risks to patients, in her opinion, that have to be addressed.

First, she is concerned that some imported drugs may not be safe and effective because they were not subject to a rigorous regulatory review prior to approval. Second, she says the drugs ''may not be a consistently made, high quality product because they were not manufactured in a facility that complied with appropriate good manufacturing procedures.''

Third, the drugs ''may not be substitutable with the FDA approved products because of differences in composition or manufacturing.''

And, fourth, the drugs simply ''may not be what they purport to be'' because inadequate safeguards in the supply chain may have allowed contamination or—worse—counterfeiting.

In addition, the FDA's letter went on to cite significant ''safety concerns related to allowing the importation of nonbioequivalent products . . . and confusion in distribution and labeling between foreign products and the domestic product.''

The FDA is also concerned it does not have clear authority over foreign supply chains. In other words, there is a very real risk that imported drugs either would not make us better or, yes, could very well make us worse.

One reason we never question what is in the bottle when we go to the pharmacy to fill our prescription is because the U.S. drug supply system is a closed system. That is why it is one of the safest in the world. Everyone in the system is subject to the FDA's oversight—to these very standards—and to strong penalties for failure to comply with the law.

The FDA would have to review data to determine whether the non-FDA-approved drug is safe, effective, and substitutable with the FDA-approved version. In addition, the FDA would need to review drug facilities all over the world to determine whether they manufacture high-quality products consistently.

It is clear that keeping our drug supply safe—in a global economy in which we cannot affect the motives and willingness of others to game the system for greed and profit—is a monumental task. It is not simply allowing for the importation of lower cost medications, as the proponents of this amendment would have us believe. It will require a global reach, extraordinary vigilance, and a serious investment to enforce the highest standards in parts of the world that have minimal standards now, so we don't have to ask which drug is real and which is counterfeit; so we don't have to wonder, if the packaging looks the same: Is it approved Tamiflu or is it counterfeit Tamiflu? The packaging looks the same, but is the content the same? One is approved; one is counterfeit.

When the swine flu was coming through and everybody started trying to get hold of Tamiflu, what did they do? They went online and got counterfeit Tamiflu which didn't do the job. In this photo, the answer is no. One is real, one is counterfeit. You can't tell the difference. Is this helping people save money, if they just paid for a counterfeit product? No. Is this an effective treatment for a contagious H1N1 flu, if you have just been fooled by a counterfeit bottle of Tamiflu because you thought it was cheaper? No. How is this in the best interest of the American people?

Here is another example—Lipitor. Can you tell which is counterfeit or approved Lipitor? They look the same. Americans who purchase them are told they are the same, but how do you tell the difference? Most people can't. So they will go about their normal routine each morning taking the so-called Lipitor, thinking they are treating their high blood pressure, but really they are walking around with the same silent killer and not taking the appropriate medication for it.

Another example, Aricept, a drug to slow the progression of Alzheimer's disease—something my mother was taking when she was alive. Can you tell the difference between the pills in this photo? No. And that is the problem.

The global economy opens global possibilities to counterfeiting these drugs. It opens the potential for these drugs—or the ingredients used in these drugs—to find their way from nation to nation, from Southeast Asia where the problem is epidemic to one of the 32 nations listed in the amendment that supposedly are safer, and then ultimately into American homes. That is a gamble we cannot afford to take. We should not have to wonder what is in the bottle.

Americans suffering from Alzheimer's should not have to wonder if the drug they are taking is real or counterfeit. By the time they figure that out, buying a drug either online or abroad that is counterfeit or not of the same substance or of a different dosage, it could be too late to help reverse the damage, as was promised.

One final example, Celebrex, used to treat arthritis and chronic pain. Can you tell the difference between these pills? No, and neither would those who continue to suffer if they are scammed into buying the counterfeit version. One is approved, one is counterfeit.

I fully appreciate my colleagues' desire to keep the cost of prescription drugs down, but our first task is to protect the safety of Americans and to prevent counterfeit drugs from infecting the American market.

The real problem is bringing down the cost of prescription drugs as part of overall health care reform, and the real solution is expanding access to affordable drugs in the United States.

I have heard several of my colleagues refer to 9 percent increases. What they fail to mention is the deep discounts the industry provides, particularly to the government and other entities, against that increase. They do not do that because, of course, it doesn't serve their purpose.

In this fight to create affordable drugs in the United States, I take a back seat to no one. But at the same time, I strongly believe we cannot roll the dice with the health and safety of the American people. This amendment is that roll of the dice. We should never put Americans in the position of having to worry about whether their medicine will make them better or worse. We should never put Americans in a position of wondering is that a real pill or is that a poison pill?

To see what happens if we allow importation we only need to look to the European Union. One of my colleagues earlier today used it as an example as to why we should pass this amendment. But I listened to the words of the European Union, and I hear quite the opposite.

Earlier this week, the European Union Commissioner in charge of this issue said:

> The number of counterfeit medicines arriving in Europe . . . is constantly growing. The European Commission is extremely worried.

To quote another section of the statement:

> In just 2 months, the European Union seized 34 million fake tablets at custom points in all member countries. This exceeded our worst fears.

It went on to say:

> Every fake drug is a potential massacre. Even when a medicine only contains an ineffective substance, this can lead to people dying because they think they are fighting their illness with a real drug.
>
> I expect the EU will agree in 2010 that a drug's journey from manufacture to sale should be scrutinized carefully.

He goes on to talk about other safeguards.

So, in fact, the very essence of what some claim is the very reason we should allow importation, the European Union is saying, quite to the contrary, that they think this is a huge problem for them and, in fact, what seems to be an action that would not hurt someone can actually mean the difference between life and death.

I don't want American families to see those fears come to life. Yes, counterfeit drugs may happen, but if we pass the amendment, we just open the floodgates. The European Union's experience only proves my concerns, not alleviates them like some others suggest. A $75 counterfeit cancer drug that only contains half of the dosage that a person has been prescribed and needs does not save Americans money and certainly is not worth the price in terms of dollars or risk to life. Let's not now open national borders to insufficiently regulated drugs from around the world.

Finally, in a different dimension, I think safety is utmost, but at a time of joblessness in this country, I don't want to offshore those jobs abroad to allow contaminated and counterfeit prescription drugs to come into this country. We are attacking the one last major research and manufacturing entity in the United States, one that has been at the forefront of the health care reform effort and put $80 billion of its own money in for reform. I want to see more partners like that in this process.

Let's reject this amendment. Let's keep our drug supply one of the safest in the world.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I ask unanimous consent we extend the period for debate only until 5 o'clock, with the time equally divided with Senators permitted to speak up to 10 minutes each; with no amendment in order during this time.

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

Mr. BAUCUS. I suggest the absence of a quorum and ask the time be equally charged to both sides.

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

The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. DORGAN. Madam President, I have listened this afternoon to some of the opposition to the legislation, the amendment we have offered trying to deal with the increasing price of prescription drugs. Those who are opposed apparently are oblivious to the question of the dramatic runup in prices for prescription drugs. They talk about counterfeiting and their worry about that. I wish to talk about that. Because if you are worried about counterfeiting—and, by the way, there is a counterfeiting issue with respect to prescription drugs in this country and several of my colleagues have described that issue—if you are worried about that, then you have to support the amendment I and Senator MCCAIN and others have offered that provides the only basis for getting to things such as pedigrees on prescription drugs, batch lots, and tracers. The only mechanism to do that is in this amendment, which will make the domestic drug supply safer, allow us to track back drugs to their origin, and will certainly allow us to import FDA-approved drugs when they are sold in other countries for a fraction of the price.

Let me describe what brings us to the floor of the Senate. To those who are opposed to this amendment, if one wants to be oblivious, I guess, fine, but the consumers will certainly notice. You want to buy some Nexium, guess what. Nexium is going to cost you $424 in this country. But if you buy it in Great Britain, it is $41 dollars; Spain, $36; Canada, $65; Germany $37. Once again, the American consumer gets to pay $424 for an equivalent amount, 10 times the cost of what it costs in Great Britain. Is that fair? To me, it is not. It is not fair to me that the American consumer is charged the highest prices in the world.

Plavix, you can see what is happening here, $133; $59 in Britain; $58 in Spain. The American consumer gets to pay $133 for the equivalent amount. Lipitor, the popular cholesterol-lowering drug, for an equivalent amount of Lipitor, the American consumer pays $125. In Great Britain, they pay $40. In Spain, they pay $32. In Germany, they pay $48. Again, the American consumer is told: You get to pay $125. I have described, over and over again, the two bottles of Lipitor, empty bottles made in Ireland by an American corporation and distributed all across the world, the most popular cholesterol-lowering drug. Same pill put in the same bottle made by the same company, FDA approved. Only difference is this one has a blue label and this one has a red one. This one went to Canada and this one to the United States. The U.S. consumer got to pay nearly triple the price. Is that fair? Not where I come from.

By the way, my colleague from Maine, who spoke moments ago, talked about a nearly 10-percent increase in the price for brand-name prescription drugs just this year. This chart shows what is happening. You take the arthritis drug Enbrel; you got a 12-percent increase this year. Singular, for asthma, this year you got a 12-percent increase. Boniva, for osteoporosis, an 18-percent increase this year in drug cost. The list goes on. Plavix, 8 percent up this year. In fact, I have a chart that shows what has happened year after year after year. The price of brand-name prescription drugs in the United States is way above the rate of inflation in every single year. In fact, during this year, the rate of inflation has dropped down here and the price of prescription drugs has gone up 9.3 percent.

Several of my colleagues, at least a couple of my colleagues have talked about the issue of counterfeit drugs. I am concerned about counterfeit drugs as well. In fact, there were proposals in the Congress that would have done what we should have done long ago with respect to ensuring a safe drug supply: attaching pedigrees to drugs, batch lots so you can trace them all the way back to their origin and trace them all the way through the chain of custody. That has never been done, and it should be done. It is in our amendment. That is the only way we will have a totally safe drug supply.

A couple of my colleagues have talked about circumstances where there have been counterfeit drugs in this country. That is true. Those were domestic drugs, drugs inside the country. By the way, how does some of that happen when you have not only counterfeit drugs but contaminated drugs? Forty percent of the active ingredients in prescription drugs for the United States comes from India and China. Think of that: 40 percent of the active ingredients of all the prescription drugs consumed in our country comes from India or China. I described earlier today the Wall Street Journal investigative report which shows the circumstances with the active ingredient for Heparin, the production of Heparin in a building in China. This shows the development of pig intestines for the production of Heparin. You will see this in the Wall Street Journal articles and the expose. Here is a man in this building in China who is producing Heparin, stirring a rusty old pot with what appears to be a twig from a tree, clearly unsanitary conditions. That becomes ingredients for America's prescription drug supply; 40 percent of our active ingredients comes from circumstances in which there is virtually no inspection or very few inspections of those kind of places where those prescription drugs are developed.

By the way, there was a drug called Epogen produced by a pharmaceutical company, a very reputable one. There is a wonderful book written called dangerous doses by Katherine Eban. She traced this drug to a 16-year-old boy named Timothy Fagan, whose health was dramatically affected by what has happened here. This drug found its way all the way through these places, including a strip joint in Miami, a cooler in the back of a strip joint in Miami, in the trunks of automobiles, distributed through all sorts of strange and unusual places, and gets to a 16-year-old boy with devastating results because this drug had one-twentieth the strength that was supposed to have been given to this young boy for his disease. Does anybody have the capability to understand where all this happened, how it got tracked? A journalist did the investigative work to find this out. Fortunately for us, we now have a track on this one drug that affected this young boy in a devastating way.

That was not importation. That was the domestic drug supply. How can this happen? Because we don't have batch lots and pedigrees and tracers and the capability to find out where a drug is produced and where it goes from that production to the final user in every single circumstance. We have that in our amendment. It is the only way it will happen if we pass this amendment.

It is interesting to me. There was a man named Dr. Peter Rost. He was the former vice president of marketing for Pfizer Corporation. By the way, Dr. Rost also worked in Europe in the parallel trade area for 20-some years. They do this in Europe routinely. They actually have parallel trading where you can purchase drugs, one country to another, no problem. Here is what he says:

> The biggest argument against reimportation is safety. What everyone has conveniently forgotten to tell you is that in Europe reimportation has been in place for 20 years.

They say this is going to be unsafe, you can't do it. Europe has been doing it for 20 years. Don't tell me we don't have the capability if Europe can do it. Why would we do it? Because it is unfair to the American people to be paying double, triple or quadruple or 10 times the cost of prescription drugs that are being paid for by people in the rest of the world. That is unfair. It doesn't make any sense to me.

We offer an amendment. It is one of the few amendments in the Senate, in recent days and weeks, that is bipartisan. Most of the things offered are not bipartisan. This is an amendment, Dorgan-Snowe. We offer it with broad support. The late Ted Kennedy, bless his soul, sat right over there. He was a cosponsor of our amendment. JOHN MCCAIN is a cosponsor of our amendment. Senator GRASSLEY and Senator STABENOW are cosponsors.

The PRESIDING OFFICER. The Senator has spoken for 10 minutes.

Mr. DORGAN. I ask unanimous consent for 5 additional minutes.

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

Mr. DORGAN. This is broadly bipartisan. It is one of the few bipartisan amendments. My expectation is, we will have a vote on the Crapo motion. He offered his last evening and I offered mine last evening. My expectation is

we will have a vote on the Crapo motion and then a vote on this amendment and move on. I would hope we will have the votes on this. It is the only thing in any health care proposal in the House or the Senate that starts to put the breaks on the escalating prices of prescription drugs. It is the only thing. Without this, we will pass health care reform, if, in fact, it passes and if someone says to you: What have you done to try to put the brakes on the fact that prescription drugs are increasing at 9 and 10 percent? What have you done about that? The answer is going to be, we didn't do anything. We just couldn't do that.

The fact is, a whole lot of people in this country use prescription drugs regularly to control their cholesterol, their blood pressure, and otherwise manage diseases. It keeps them out of the hospital. The fact is, many of these prescription drugs are very important in the lives of people. The question for us is, if we are allowing these drugs to be priced out of the reach of people, what does that say about the value of the drugs? We need to have fair pricing for the American people. We must insist on fair pricing for prescription drugs for the American people. It is that simple. This notion of there being any kind of a safety issue is a total canard by those who ignore the very provisions of the bill that establish the most rigorous regime of safety ever established for the domestic drug supply and for the reimportation of prescription drugs. That is just a fact.

My hope is, in very short order, we will have an opportunity to have the Members of the Senate cast their votes on this and, at long last, Senator SNOWE and I, having been at this, I think, now for 8 or 10 years, will have at the right time—and that is health care, when you are considering health care, when is a more important or more appropriate time to consider the questioning of prescription drugs—and in the right place, the ability to pass the legislation. We offer a bill as an amendment. Thirty Senators having cosponsored it, Republican and Democrats, conservatives and liberals and moderates having cosponsored it. It is my expectation, we will have this vote and at long last be successful in doing something for the American people.

The question is, does the pharmaceutical industry have a lot of clout? The answer is, they sure do. As I said many times, I have no beef against that industry. I want them to succeed and earn profits. I think their pricing strategy is unfair to the American consumer. Do they have a lot of clout. Yes, they do. But it is my hope that when it comes time for a vote, the American people and the interests of the American consumers will have as much clout in this Chamber, based on the facts, facts that suggest the American people ought to be treated fairly.

This amendment is all about freedom, giving the American people the freedom to do what everybody else can do and that is participate in the global marketplace. When the medicine they need that is FDA-approved is available somewhere else for half price or for an 80-percent reduction, why on Earth should they not be able to acquire that lower priced drug that is FDA-approved? The answer is, they should have the freedom to do that. The only way that freedom will exist is if we pass this amendment. That is just a fact.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I yield the time remaining on our side to the Senator from Maryland.

Might I ask, how much time is that?

The PRESIDING OFFICER. There is 4 minutes 40 seconds.

Mr. BAUCUS. Madam President, not withstanding the prior agreement, I ask unanimous consent that the Senator from Maryland be allowed to speak for 10 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. Madam President, I might amend that by asking unanimous consent that the Senator from Kansas also be recognized for 15 minutes following the Senator from Maryland.

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

The Senator from Maryland is recognized.

Mr. CARDIN. Madam President, I ask unanimous consent that I be able to speak as in morning business.

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

(The remarks of Mr. CARDIN are printed in today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from Kansas.

Mr. ROBERTS. Madam President, I understand I am recognized for 15 minutes; is that correct?

The PRESIDING OFFICER. That is correct.

Mr. ROBERTS. Madam President, I understand the distinguished Senator from Michigan wishes to attend the very important Democratic conference on a brand new health care bill. I understand that, and I shall try to expedite my remarks, only with the suggestion to the Presiding Officer that when you are late in the Senate, you are early, and they are not going to say anything important without you.

I wish to yield at this time to the distinguished Senator from Georgia, who I understand has a statement to make.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. CHAMBLISS. Madam President, I thank my friend from Kansas.

I rise to discuss the tax implications that this health care bill will have on Americans.

Last year, President Obama made a promise to the American people. He assured us over and over that he would not raise ''a single dime'' of taxes on Americans earning less than $250,000 per year.

But the health care bill presently before this body—the very bill that the President has demanded—will not only raise taxes, it will create new ones.

And as of yet, we have no idea what the Congressional Budget Office will say about how much the deal my colleagues apparently struck last night will cost taxpayers.

But we know that this $2.5 trillion proposal is going to hit three groups with new or higher taxes: families, businesses, and the health care industry itself. And we know that under the current bill taxes overall are estimated to go up by $867 billion.

Tax hikes are detrimental at any time. But they are doubly hurtful in the bad economy we are in.

Under the terms of this bill, in 2019, more than 42 million individuals and families—this is 25 percent of all tax returns under $200,000—will see their taxes increase.

In addition, if we pass this bill, the Congressional Budget Office estimates that $36 billion in new taxes and fines will be forced upon individuals and businesses.

Families without insurance would be fined up to $2,250. And according to the Joint Committee on Taxation, some of those are expected to have incomes below $200,000.

Also, businesses with more than 50 workers that do not offer coverage will be forced to pay a penalty of $750 for every full-time worker if any of those workers get subsidized coverage through insurance exchanges.

Many of these businesses will not be able to afford the cost of providing health insurance or the fine. According to the CBO, 5 million Americans will lose employer coverage. Others may find their pay reduced so employers can cover the cost of these new taxes and fines.

This bill has been sold as an attempt to ''help businesses be more competitive in the marketplace.''

But the National Federation of Independent Business—which actually represents small businesses—disagrees.

In a letter to the majority leader, the NFIB was very clear—and this is a quote: ''The current bill does not do enough to reduce costs for small business owners and their employees.'' It also called this bill ''the wrong bill at the wrong time.''

Also hit hard would be the health care industry and medical-device manufacturers.

Now, it may not be popular to worry about fees imposed on health insurers and the like, but the fact is, the $100 billion in taxes and fees this bill will impose on them will be passed on to Americans in the form of higher premiums. That is also according to the CBO.

Our health care system needs to be reformed. We absolutely need to cover those with preexisting conditions, and

Americans in the medical fight of their lives should not be kicked off their insurance.

But swapping out a system that needs fixing with just another broken system that also raises taxes on Americans who need every dime of their paychecks to get through the month is not the way to go.

We need to move in the right direction. We need to emphasize wellness and prevention.

We need to reduce frivolous medical malpractice lawsuits that add so much to the cost of practicing medicine. Senator GRAHAM and I have introduced a ''loser pays'' bill that would do just that.

We also need to allow health insurance purchases across state lines, and allow small businesses to pool resources to buy insurance for their employees.

But do we need an insurance tax, an employer tax, a drug tax, a lab tax, a medical device tax, a failure-to-buy-insurance tax, a cosmetic surgery tax, and an increased employee Medicare tax?

We don't need to impose eight new taxes on the American people.

The absolute last thing we should be doing during the worst economy we have had in decades—with 10 percent, 26-year-high unemployment—is hiking taxes on the middle class and on small businesses, both of which are the backbone of America.

The NFIB is right—this is the wrong bill at the wrong time.

Madam President, I thank the Senator from Kansas.

Mr. ROBERTS. Madam President, President Obama has repeatedly made two pledgees to the American people—and we have heard it and heard it before, and we will probably hear it again—about health care reform. The first is, if you like the health care you have, you can keep it.

We know the bill before us breaks this pledge because all but two in the majority voted to preserve the nearly $500 billion in cuts to Medicare, which includes $120 billion in cuts to Medicare Advantage.

The nonpartisan Congressional Budget Office, or CBO, has confirmed that these cuts to Medicare Advantage mean that ''approximately half'' of the Medicare Advantage benefits will be cut for the nearly 11 million seniors who are enrolled in this program.

This vote confirms whether Americans will be able to preserve and keep the health care benefits they have and like. That answer, unfortunately, is no.

So now let's look at the President's second pledge: that he will not raise taxes on families earning under $250,000 or individuals earning under $200,000.

A number of my colleagues have pointed to comments made last year in Dover, NH, by then-Candidate Obama, who said:

I can make a firm pledge—

And we have heard this before—

. . . no family making less than $250,000 will see their taxes increase—not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.

I think he said ''by one dime'' at the end of that.

Yet time and again in this bill, that pledge is also broken. This bill calls for nearly $500 billion in new taxes, penalties, and fees that hit virtually every American, including middle-class families making less than $250,000 and individuals earning less than $200,000.

Even though the majority has tried to disguise these taxes as various ''fees'' and presents them as being paid for by targeted health care industries, the reality is that this bill taxes the average American coming and going.

It taxes you if you have health insurance. It taxes you if you do not have health insurance. It taxes you if you use medical devices, such as a hearing aid or a pacemaker. It taxes you if you save on your own to pay for your health care expenses. And it effectively increases taxes for individuals and families with catastrophic medical expenses.

Americans should understand that the higher taxes called for in this bill will come straight out of their pockets, with the middle class bearing much of this tax burden.

Let me give you a few examples of the new taxes proposed and who will pay for them.

The bill imposes a 40-percent excise tax on health insurance providers that offer high-cost health insurance plans. This provision is the largest tax hike in the bill and raises almost $150 billion and will be paid for primarily by individuals—not the health insurance provider, but by individuals—through increased income and payroll taxes.

By the time this bill is fully implemented, 84 percent of this tax on ''high-cost plans'' will be paid by Americans who earn less than $200,000—taxpayers the President promised would not pay additional taxes.

Second, the bill imposes new taxes on health insurance providers and medical device manufacturers. Both the nonpartisan Congressional Budget Office and Joint Committee on Taxation have said these taxes will be passed on to consumers in the form of higher insurance premiums. The new $60 billion tax on health insurance providers alone could raise premiums by as much as 2 percent according to some analyses, and that increase could come as early as next year.

Not only that, the $19.3 billion in new taxes on medical devices could increase costs for up to 80,000 medical products, such as heart stents, blood pressure monitors, eyeglasses, pacemakers, hearing aids, and advanced diagnostic equipment. Such a tax would stifle and will stifle innovation and reduce the ability for manufacturers to develop new lifesaving devices and technologies.

So make no mistake, the cost of this tax will be passed on to and paid for by anyone who uses a medical device, including those middle-class taxpayers the President has pledged will not experience any tax increase.

If you need a pacemaker or a stent, you will pay more for it because of these new taxes. If you need a diagnostic procedure, you will pay more for it because of this new tax.

Furthermore, under this bill, the floor for deducting medical expenses from income tax is raised from 7.5 percent to 10 percent of adjusted gross income. Those who will take this deduction are most often seniors and those with serious or catastrophic medical issues.

For a family of four, earning $57,000 in 2013, limiting the deduction means they would lose a tax deduction of $1,425. A family of four earning $92,000 would lose a tax deduction of $2,300.

It goes without saying, I think, that losing a portion of your tax deduction means you pay more in taxes. These are real dollars to hard-working Americans. This provision alone raises $15 billion in new taxes on Americans who deduct medical expenses.

Finally, this bill raises taxes for the more than 35 million Americans who participate in flexible spending accounts, or FSAs. For the first time, this benefit to middle-income workers is taxed to pay for new government spending and an expansion of entitlement programs.

FSAs are a key benefit for many families for whom health insurance does not cover or does not cover sufficiently some of their highest cost health care expenses such as dental, vision, as well as prescription drug costs. They are also important for individuals who manage chronic diseases such as diabetes, heart disease, or cancer.

Flexible savings accounts allow the participants to set aside money out of their own pocket to pay for these necessary expenses. However, under this bill, the government caps how much can be set aside in an FSA account at $2,500, effectively raising the tax burden on certain FSA participants and increasing their health care costs.

The typical worker who contributes more that $2,500 to their FSA has a serious medical condition. This means that under this bill, workers with serious illnesses and earning an average of $55,000 will be paying more in taxes.

I have highlighted a few of the many tax hikes in this bill and the fact that the middle-class taxpayers will bear the brunt of these higher taxes, but if there are any doubts remaining about what this bill means for Americans' pocketbooks, let's consider this. An analysis by the nonpartisan Joint Committee on Taxation looked at four tax provisions in the bill and how, when taken together, they will affect Americans. They looked at the tax credit for health insurance, the additional Medicare payroll tax, and several I have already mentioned, including the high-cost plan tax and the medical expense deduction limit. Their analysis shows that when this bill is in full effect, on average individuals making over $50,000

and families making over $75,000 would see their taxes go up under this bill. Even after taking into account the premium tax credit, the subsidy that the government will provide to help people offset the cost of health insurance, when this bill is fully in effect, more than 42 million individuals and families or 25 percent—one-quarter of all tax returns under $200,000—will see on average their taxes go up as a result of this bill.

In addition, based on the same information, the Joint Committee on Taxation identified two groups of taxpayers. The first are those individuals and families who are not eligible to receive the premium tax credit to purchase health care, and second are those individuals and families whose taxes will increase first before they then see some type of tax reduction as a result of their premium tax credit. Taking these two groups together, the number is even more disturbing: 73 million individuals and families or 43 percent of all tax returns under $200,000 will on average see their taxes increase under this bill, says the Joint Committee on Taxation.

To put it another way, under this bill, for every one individual or family that benefits from the tax credit to purchase insurance, this bill raises taxes on three middle-income individuals and families. These tax increases are on top of those I discussed earlier, such as the new taxes on FSAs, so the estimates I have already mentioned understate the tax impact, again, on middle-income taxpayers. The JCT the Joint Committee on Taxation—has confirmed that these additional taxes, such as the FSA tax, will likely further raise the taxes of middle-income Americans.

All Americans, and middle-class taxpayers especially, need to take notice of what these higher taxes will mean for them and their families. They need to know these taxes will be used in part to pay for a vast expansion of the role of government in health care and more government intrusion into families health care choices.

Paying for health care on the backs of the middle-class and working Americans is the wrong solution for health care, violates the President's pledge to these taxpayers, and is terribly counterproductive in regard to the No. 1 issue facing this country, and that is jobs and the economy.

I urge my colleagues—I plead with my colleagues—to support the Crapo motion to prevent the enormous tax hike this bill inflicts on middle-class Americans.

Mr. President, I appreciate your indulgence. I know you are ready to go to your conference.

I yield the floor.

The PRESIDING OFFICER (Mr. NELSON of Florida.) The majority leader is recognized.

RECESS

Mr. REID. Mr. President, I ask unanimous consent the Senate stand in recess until 6:15 p.m. today; that upon reconvening at 6:15, the Senate continue in debate-only posture for an additional hour under the same conditions and limitations specified under previous orders.

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

Mr. REID. Mr. President, I would also tell everyone here there will be no more votes tonight. I don't think we can arrange any.

Thereupon, the Senate, at 5:06 p.m., recessed until 6:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. BROWN.)

SERVICEMEMBERS HOME OWNERSHIP TAX ACT OF 2009—Continued

The PRESIDING OFFICER. The Senator from South Carolina is recognized.

Mr. GRAHAM. Mr. President, I assume it is our turn to talk a bit.

Mr. BAUCUS. Mr. President, I remind all Senators that we have an hour, equally divided, with each Senator able to speak up to 10 minutes each.

Mr. GRAHAM. I appreciate that. I appreciate the effort to try to solve a hard problem. It is easy to criticize in this business, and it is hard to bring folks together. Maybe one day we can solve a hard problem where we get 70 or 80 votes. I don't think this is that day.

One thing I will point out about the process is that somehow between the time this started until now, something went wrong. This is what happened. This is what was said by Candidate Obama in January 2008:

> That's what I will do in bringing all parties together. Not negotiating behind closed doors, but bringing all parties together and broadcasting these negotiations on C–SPAN so that the American people can see what the choices are.

In November 2007, he talked about, in his Presidency:

> We are going to have a big table and everybody is going to be invited—labor, employers, doctors, nurses, hospital administrators, patients, and advocate groups. The drug and insurance companies, they will also get a seat at the table, and we will work on this process publicly. It will be on C–SPAN. It will be streaming over the Net.

March 2008:

> But here's the difference: I'm going to do it all on C–SPAN so the American people will know what's going on.

August 2008:

> When we come together around this health care system, I am going to do it all in the open. I am going to do it on C–SPAN.

August 2008:

> I am going to have all the negotiations around the big table. We will have the negotiations televised on C–SPAN.

The truth is, Mr. President, I am not so sure negotiating on C–SPAN is the way to find a solution to hard problems. But being at the table with all parties represented is probably a very good idea. And the process, as I understand it now, is that our Democratic colleagues are trying to negotiate among themselves to get to 60 votes. There was an announcement made last night by the majority leader that we have had a breakthrough. He said, ''I can't tell you what it is, but it is good.''

Mr. President, that is not the way we want to change one-sixth of the economy. I argue that is not the best process by which to make major decisions that affect the quality of Americans' lives.

The idea of Medicare being changed so dramatically by one party is probably not a good idea. What have we done on the Medicare front? The actual bill that has been proposed increases spending by $800-something billion. To pay for that, there are cuts in Medicare of close to $400 billion to $500 billion. The money that would be taken out of the Medicare system is not plowed back into Medicare but used to fund other aspects of this bill. This is at a time when Medicare—the trust fund—is $36 trillion underfunded and will begin to be exhausted in 2017.

I argue that both parties should be trying to find a way to save Medicare from the pending bankruptcy and do something about entitlements in general, Social Security and Medicare, to make them solvent so that, one, they don't run out of money and we don't have to raise taxes in the future or cut benefits for young people because those are the choices we will pass on to the next generation if we do nothing.

Instead of coming together to save Medicare from bankruptcy, we are actually reducing the amount of money going to an already-strapped system and using it for something else. There is another idea floating around that one of the solutions that may come out of this deal, which we don't know the details of yet, is we are going to allow more people to buy into Medicare under the age of 65, and we will be expanding the number of people going into a system that is already about to go bankrupt. If we add new people to the system, approaching insolvency, something has to give. Who will be coming into the system from 55 to 64? I argue those people are going to be in as a result of the process of adverse selection, people who have health care problems. It is going to put more pressure on a system that can't stand one more drop of pressure. That doesn't make a whole lot of sense to me.

We know this Medicare system is very much under siege, that the baby boomers are about to come into the system by the millions. There are three workers for every retiree today, and in 20 years there are going to be two. So what do we do? We take money out of the Medicare system and use it for other things, and we are adding more people into the system that are going to drive up the cost overall to those already on Medicare.

So if you are over 65, your ability to receive treatment is going to be compromised because now we have to accommodate more people. If you don't believe me, ask the hospitals and doctors who are very worried. The Medicare reimbursement system now makes it very difficult for doctors and hospitals to pay the bills. So the hospital association, the Mayo Clinic, and others have warned Congress: Please don't expand Medicare because we can't survive on the reimbursement rates we have today.

If we add more people, we create more stress on a system that is hanging by a thread. I argue that is not change we can believe in or accommodate. If you had run for President on the idea that you are going to put more people on Medicare and expand that system, not reform it, take money out of it and use it for another purpose, you would have never had a chance of getting elected. No one during the campaign for President ever suggested any of these ideas.

I just hope we will, as a Congress, stop and think about what we are doing and realize if we do this—if we cut Medicare and expand the number of people who will be in the system—we make it impossible to save it down the road and make it difficult for people coming behind us to have the same quality of life we have enjoyed. Between Medicare and Social Security and other entitlement programs, we are about $50 trillion short of the money we are going to need in the next 75 years to pay the bills.

In trying to reform health care, we have taken a weak system and almost made it impossible to reform. We have expanded taxes at a time when the economy can't bear any more tax burdens because part of the bill raises taxes by about $500 billion. You will never convince me or anybody else that if you raise $500 billion in taxes to pay for this new health care bill, it would not affect the economy in general. There has to be a better way.

I am on the Wyden-Bennett bill. I am a Republican who agrees with mandated coverage for everybody. Senators WYDEN and BENNETT have a comprehensive proposal that is revenue neutral. We would take the tax deductions given to business over a period of time and give them to individuals so that all of us would have tax deductions to go out and purchase health care in the private sector. We would have exchanges where we can go shop for health care that is best for us.

If you are single and 22, you would want a plan that is different than if you were 45 and had 3 kids. The tradeoff is that the Republicans, on the Wyden-Bennett bill, would agree to mandate coverage. The Democrats would allow people to purchase health care in the private sector. We would all use the Tax Code to fund those purchases. If you didn't make enough money to have the tax deductions, you would get a subsidy. That makes perfect sense to me.

I want to solve the problem. I want to make sure everybody is covered because a lot of us are paying health care bills for those who are not covered that could afford to pay—about 7 million or 8 million people make over $75,000 a year, and they don't pay anything for health care of their own. So the rest of us have to pay it when they get sick. That is not right.

There is a better way, in my view. I just hope we will understand that what we are doing with one-sixth of the economy is going to have a lasting effect on the quality of American life, and now is not the time to cut Medicare or add more people to it. Now is the time to come together in a bipartisan fashion to save Medicare from impending bankruptcy. Now is not the time to raise taxes.

I hope our colleagues will understand that there is a better way.

I yield the floor.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Ohio be recognized following my statement.

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

Mr. REID. Mr. President, I had a conversation earlier today with the distinguished Republican leader. It appears now that we are going to get the appropriations bill from the House of Representatives. The bill is bipartisan, and everybody has worked hard. There are some conference reports we have completed. Yet we didn't find them to work on the floor, for reasons everyone understands. That bill will come over from the House tomorrow. We can move to that with a simple majority vote, and then if I have to file cloture on it tomorrow, we would have a Saturday cloture vote. Thirty hours after that—sometime Sunday morning—we would have a vote on the conference report.

I have indicated to the Republican leader that it would probably be to everyone's advantage if we allow people to go home for the weekend, rather than going through all these procedural gyrations.

We have worked hard. I had a Senator come to me and say she hadn't been home in 2 or 3 weeks, and it was not a good situation. That Senator said if we have to be here this weekend, she will be here. We need to not be doing things just to delay. I understand the Republican leader doesn't want to do health care. I appreciate that, and we have different positions on that issue.

I see no reason to punish everybody this weekend. I hope the minority will give strong consideration to the proposal I have made. We are waiting for a score to come back from CBO anyway. Anybody who has had experience with CBO knows that will take a matter of days. So I hope the minority will allow a little bit of time to go by so that we can have our respite from the tedious work we have been doing on the Senate floor.

The PRESIDING OFFICER (Ms. CANTWELL). The Senator from Ohio is recognized.

Mr. BROWN. Madam President, I have come to the floor most days reading letters from people in Ohio—from Springfield to Mansfield to Marion—who thought they had good insurance a year or two ago, if you asked them, but found out their insurance was not so good when they had a preexisting condition or when they got very sick and the costs were high and the insurance companies cut them off. In some cases, as the Presiding Officer knows, in my State and across the country, women so often are paying higher premiums than men.

Our bill will fix a lot of those things. One of the things the bill still needs to fix—and we have gotten letters on this—is what happened with the price of prescription drugs. There are many things I like about the bill and a few I don't. Here is one.

I rise to support the Dorgan amendment No. 2793. I will start with a story.

About a decade ago, maybe a little more than that—I live in northern Ohio—and I used to take a bus load of senior citizens every couple of months—maybe a dozen times—from Elyria to Sandusky into Toledo and into Detroit and into Ontario—across the river into Windsor, Ontario. I did that so seniors could buy less expensive prescription drugs. I would go into a drugstore in Windsor—same drug, same packaging and dosage, but the price would be one-half, sometimes one-third of what seniors paid in the United States. In many ways, it broke my heart that, as a Federal official, I was going to another country to buy something that was more often than not made in the United States, when the drug companies charge twice or three times that to the United States as in Canada. But I thought it made sense for seniors in my State—congressional district in those days—to go to Canada and be able to get those prescriptions.

They then would be able to get a refill every 3 or 6 months at least a couple times with that doctor's signature they got in Canada to buy those drugs.

I appreciate Senator DORGAN and Senator SNOWE offering this amendment. I hope it is signed into law as part of health care reform. If the drug companies were struggling and not making any money, it would be a different situation. Drug companies earn higher profits than almost any other industry in America. In fact, they have been one of the three most profitable industries in our Nation for decades.

Just last year, the pharmaceutical industry was the third most profitable industry in America, ranking right up there with the oil conglomerates.

Let's face it, to call these corporations American is a stretch. Most of them are multinational, and most reap huge profits from around the globe.

It is true they earn higher profits in our country than in any other, but that hardly qualifies them as patriotic.

As drugmakers earn billions, U.S. drug spending is fueling double-digit increases in health insurance premiums. There is a reason health insurance premiums go up. Certainly, the insurance industry is one of the reasons. We know about insurance industry profits. We know about insurance industry executive salaries. In the 10 largest health insurance companies in this country, CEO's average around $11 million in income. That is part of the reason.

Another reason is drug prices continue to fuel the high cost of health insurance. Drug prices continue to drain tax dollars out of the Federal Treasury, and drug spending is undermining the financial security of millions of seniors and other Americans, of course, but especially seniors who can ill afford to be the piggy bank for big PhRMA's—that is a drug company trade association—global operations.

Because we do not allow importation—a decision our government has reached in all too close consultation with the drug lobby—Americans are forced to pay more for the same drugs than everyone else in the world.

It is not about safety. We know that. The equivalent of the Food and Drug Administration in Canada or in France or in Germany or in Israel or in Japan knows how to make sure drugs are safe in their country. It is not a question of safety. It is a question of industry profits.

Prohibiting importation has cost American consumers and taxpayers dearly. It has driven up the cost of insurance premiums and it has driven up the cost of Medicare, paid by taxpayers, Medicaid, paid by taxpayers, TRICARE, paid by taxpayers, and all Federal health care programs, again paid by taxpayers.

It has reduced—and this is equally important—not just the cost, but it reduces access to lifesaving medicines. Some people simply cannot afford the cost of these drugs. It has reduced seniors' budgets to the point where they buy groceries or heat their homes or purchase prescription drugs but not both. Too often seniors cut their pills in half, take their prescriptions in smaller doses, and that, obviously, is jeopardizing health also.

This amendment is a step in the right direction for increasing access to those drugs.

In 2008, the pharmaceutical industry had more than a 19-percent profit margin and had sales of $300 billion. I am way more interested in protecting U.S. consumers, U.S. taxpayers, and U.S. small businesses that are burdened by these high drug costs than I am U.S. drugmakers and their inflated drug prices.

The CBO estimates this amendment will save the government $20 billion over the next 10 years—$20 billion. I wish to encourage more competition. I do not want this body, again, to come down on the side of preserving monopolies.

As it stands now, the U.S. Government permits the drug industry to hold American consumers hostage. Meanwhile, the largest drug companies—Pfizer, Merck, and others—continue to outsource operations abroad to cut costs and increase profit margins.

Here is what happens: It is OK for big PhRMA to look abroad to cut costs and boost profits while American consumers and businesses are stuck paying the bill. The drug industry is trying to convince us—the Senate, the House and, more importantly, trying to convince the American people—that importation is unsafe. Wait a second. They go to China—I had hearings about this in the Health, Education, Labor, and Pensions Committee. We have had hearings, which Senator Kennedy, a couple years ago, asked me to chair, involving American drug companies outsourcing their production to China. They could not tell us about the entire supply chain that supplied the ingredients to these drug operations in China that later made their way back to the United States. We know about Heparin, a drug that killed several people in Toledo, OH, because it was contaminated with who knows what ingredients that came from China.

So these drug companies are arguing these products are unsafe, these drugs you can buy in Windsor, Ontario, or pharmaceuticals you can buy in Bristol, England, or pharmaceuticals you can buy in Marseilles, France, or pharmaceuticals you can buy in Dusseldorf. They are saying those are unsafe, but they are unwilling to import drugs themselves.

Lipitor, one of the best-selling drugs in the United States, for years, was made in Dublin. They can import their drugs from abroad. They can import ingredients from China, which has nothing like the Food and Drug Administration, and they are going to hire all their lobbyists and they are going to go around desk to desk, Member to Member, office to office—435 House Members, 100 Senate Members—and they are going to tell us these drugs are unsafe? We know better than that.

This amendment would simply make imported medicines available to consumers. It is a free-market mechanism. Open it so people can compete, giving customers more purchasing power so they can pay lower prices. The drug industry should not be protected from the same competition that every other industry faces in a global marketplace.

I urge my colleagues to support the bipartisan amendment of Senator DORGAN from North Dakota, Senator SNOWE, Senator GRASSLEY, and Senator MCCAIN—all three Republicans from Maine, Iowa, and Arizona. This amendment makes sense for taxpayers. It makes sense for consumers. It makes sense for businesses. It makes sense for our country.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. THUNE. Madam President, I wish to speak to a couple issues this evening. The first one has to do with what we understand to be the evolving so-called deal that is being worked out by the other side on the public option/government plan and the attempt to try and reach 60 votes on the other side, in what appears to be a process that continues to unravel and break down because every single day there is a new story about some new gimmick thrown out there to attract the requisite number of Senators to get to that threshold of 60.

The most recent one—and, of course, as I said, I cannot verify all of this because we have not been privy or included in any of the discussions that have occurred behind closed doors. In fact, one of those meetings just occurred earlier this evening.

We read from press reports that one of the proposals contemplated by the majority to get that requisite number of votes is the expansion of the Medicare Program. What is interesting about that is that has engaged organizations that prior to this time had essentially been at the table and negotiated their own kind of agreement. But that has gotten the interest level up of the American Hospital Association, the Federation of American Hospitals, the AMA, the physician group, and I even have something here from the Mayo Clinic.

It is interesting that would be considered now as an alternative to what previously had been discussed in terms of a public option. Here is why. Medicare, as we all know, is destined to be bankrupt in the year 2017. It is a very large program that benefits a lot of seniors across the country. We all support reforming it, making it more sustainable, putting it on a pathway to where it will be solvent well beyond that date and extending its lifespan.

What this would appear to do is allow people younger than 65 or 62, down to 55, to buy into Medicare. Essentially, you would allow more people to participate in a program that, as I said before, is destined to be bankrupt in the year 2017. So what you are doing with this proposal—because we all know the underlying bill cuts Medicare reimbursements to hospitals, nursing homes, hospices, home health agencies, and to Medicare Advantage beneficiaries by about $1 trillion over 10 years, when it is fully implemented—you are going to take $1 trillion of revenue out of Medicare—remember, this is a program that is already destined to be bankrupt in 2017—you are going to take $1 trillion of revenue out of it over the 10-year period, when it is fully implemented, and expand and add the number of people who are going to be on it. It is equivalent to putting more people on a sinking ship. In fact, that is what has gotten the attention of provider groups around the country.

Hospitals, as we know, cannot recover their costs with the reimbursements they are currently receiving under Medicare. In most States, it varies a little bit—80 to 90 cents on the

dollar. So hospitals, every time they serve a Medicare patient, shift that cost over to the private payers and increase costs for everybody who is receiving insurance in the private market.

Essentially, what you will be doing is expanding the government-run Medicare Program which underreimburses hospitals, physicians and other health care providers and forcing even more of a cost shift. You are exacerbating the cost shift already occurring, making it worse and getting all the provider hospital groups—the American Hospital Association, the American Medical Association—engaged in this debate because they see what a train wreck it would be for them.

Frankly, what that means is you would have a lot of providers that would not be able to make ends meet. They would have to shut their doors and go out of business because many of them are very dependent on Medicare patients.

In my State of South Dakota, most of our hospitals, especially in rural areas, are heavily dependent—70 percent or thereabouts—between Medicare and Medicaid. If they are not a critical access hospital and still getting reimbursed under the traditional Medicare Program, they are going to have a very hard time making ends meet because right now what they do is what all hospitals do. They shift costs over to the private payers.

Here is what AMA said about the proposal:

> AMA has a longstanding policy of opposing expansion of Medicare given the projections for the future.

That is what the doctors group said.

The American Hospital Association urged all Senators to reject expansion of Medicare and Medicaid as part of the public option, saying Medicare pays hospitals just 91 cents of each dollar of care provided. This again would expand the number of people they would have to cover and shrink the private-payer market and lump more and more of the costs on those so everybody else's premiums would go up.

The Federation of American Hospitals, which is the private hospitals across the country, said any Medicare buy-in would invariably lead to crowdout of the private health insurance market, placing more people into Medicare. Such a policy will further negatively impact hospitals after we have already agreed to contribute a maximum level to sustainable reductions in the deal they struck earlier. It seems to me these deals have fallen off the table.

This latest proposal—if, in fact, what we are reading is true—I think they recognize would be a disaster. Here is what the Mayo Clinic in their letter said:

> Any plan to expand Medicare, which is the government's largest public plan, beyond its current scope does not solve the nation's health care crisis, but compounds it.

They go on to say:

> Expanding the system to persons 55 to 64 years old would ultimately hurt patients by accelerating the financial ruin of hospitals and doctors across the country. A majority of Medicare providers currently suffer great financial loss under the program. Mayo Clinic alone lost $840 million last year under Medicare. As a result of these types of losses, a growing number of providers have begun to limit the number of Medicare patients in their practices.

That is what we are talking about. If you expand this program and you have a reimbursement system that currently does not cover the cost of hospitals, they are going to cease covering Medicare patients in the same way they currently are not covering Medicaid patients.

They say about 50 percent of physicians today have chosen not to accept Medicaid patients. So you compound the access problem that many people in rural areas already experience.

There are big problems with this proposal. I have to come back to what Congressman Anthony Weiner said about this issue:

> Extending this successful program to those between 55 and 64, a plan I proposed in July, would be the largest expansion of Medicare in 44 years and would perhaps get us on the path to a single payer model.

Therein, I think, lies the ultimate goal, and that is to expand Medicare to where we have a whole government-run health care system in this country on the way to single-payer status. That is precisely what many of our colleagues on the other side want to see happen.

Ironically, there are some who have expressed concern about this. Our colleague from North Dakota, the chairman of the Senate Budget Committee, Senator CONRAD, said when asked about this proposal:

> It's got many of the same problems I have with previous versions of the public option. That then ties you to Medicare levels of reimbursements for a whole new population.

He contended that the hospitals in his State would go bankrupt. His State of North Dakota is not unlike my State of South Dakota. Hospitals are not going to be able to make it if these reimbursement levels that are currently afforded them under Medicare are extended to a whole new population.

I hope this is a bad idea that is just being thrown out as one of these things that is being thrown at a wall and hoping it sticks in a desperate effort to get to 60 on the other side because this is a bad idea and the provider groups are weighing in heavily against it.

It is pretty clear it would be a disaster for health care delivery in rural areas of the country and, for that matter, Mayo Clinic and many of the providers that weighed in on this. It would literally make it more difficult for people to have access to health care and exacerbating the cost-shifting issue that already exists with regard to the private-payer market and make their costs and everybody else's costs go up more.

I want to shift gears for a moment because tomorrow Senator HUTCHISON and I will be offering a motion to commit. Basically, what it deals with is the whole tax component of this health care reform bill. In very simple terms—and I will demonstrate exactly why this is a relevant issue—if you look at the cost of this health care proposal, the Reid proposal before us, you can see what the costs are in the early years and then you can see how the costs explode in the outyears. There is a reason for that. The revenues kick in right away. The tax increases start coming in right away, but the spending proposals and many of the benefits that will go out under this bill don't occur until much later.

So what we have is a 10-year budgetary picture and cost for this program that completely understates what the true cost of the program is. If you look at this particular chart, look at the years 2010 to 2019, you can see how, particularly in the early years, it doesn't look like there is that much spending. In fact, the number in the first 10 years is $1.2 trillion in spending. However, if you look at the cost of this when it is fully implemented—take the year 2014 and extend it through the year 2023—you can see how the costs explode, and the total fully implemented cost over a 10-year period is $2.5 trillion.

There is a reason for that, as I said. A lot of budgetary gimmicks were used to understate the cost, particularly in the first 10 years, so people could say it costs only $1 trillion. In fact, as you can see, when it is fully implemented, it is $2.5 trillion. One of the major reasons for that is because the tax increases in the bill take effect 23 days from now—January 1 of the year 2010. That is when many of the tax increases in this legislation go into effect. But the spending and the benefits that are going to be distributed—the exchanges and the premiums, the premium subsidies, and that sort of thing, the tax credits—don't begin to kick in until the year 2014 or 1,484 days later. So for those 1,484 days—well, back out the 23 days from that—so for those 1,461 days, taxes are going to be assessed and levied against people in this country—on small businesses, families, and individuals—but you will not see any benefits for over 1,000 days, almost 1,500 days.

What the Hutchison-Thune motion to commit does is it aligns the tax increases, the fees—the taxes included in this proposal—with the benefits in terms of timeline so that the tax increases and the benefits occur at the same time. In other words, we would delay the tax increases in this bill until such time as the benefits package and structure would kick in so that they are in sync.

Right now, there is essentially 4 years—at least 4 years—of tax revenues coming in, tax increases being borne by people all across this country, including businesses. Incidentally, there is a lot of discussion now about job creation and the need to grow the economy. The worst thing you can do to small businesses, when you are trying

to create jobs, is to levy new taxes on them. But that is what this bill does. And, by the way, in that first 4 years, almost $72 billion of taxes will be collected. I say the first 4 years, I think that is through the year 2014. But you have all these taxes that kick in on January 1 of 2010—less than 23 days from now—and then actually you have this amount of time—as I said, almost 1,500 days—before the benefits begin to pay out.

So all we are saying in our motion to commit is let's align the tax increases and the benefits structure so you don't have this period of 4 years where people are paying taxes and receiving literally no benefits under this health care reform bill.

The advantage that has is that it accurately reflects the cost of this program in the first 10 years, rather than understating it because of the revenues that kick in immediately and the benefits that don't kick in until much later. It is very straightforward, very simple, very understandable. Tax increases that are designed to kick in on January 1 of this next year would not kick in until such time as the benefits kick in. So the fees, the taxes, and the tax increases in this bill are all aligned and sync'd up, so to speak, with when the spending under the bill begins.

Of course, what that does is give us a more accurate reflection of the overall cost of the bill. And many of these tax increases which will kick in 3 weeks from now, or a little over 3 weeks from now, on January 1 of next year, are going to be distributed across a wide range of businesses, but most will be passed on to consumers across this country. In fact, the CBO, in a letter to Senator EVAN BAYH on November 30 of this year, said essentially that all these fees and taxes in the bill—and there are fees on medical devices, there are fees on prescription drugs, there are fees on health care plans—all these fees would tend to raise insurance premiums. In testimony in front of the Finance Committee, the CBO, when this question was posed during the deliberations at the Finance Committee level as to what all these fees would do to insurance premiums, they said, roughly, it would increase premiums dollar for dollar.

So we have the taxes and fees that will kick in immediately, and that will have an upward impact on premiums so that people across the country will begin to see those premium increases take effect. The tax increases, of course, are taking effect on medical device manufacturers and on prescription drugs, and there is a whole other range of taxes in here—there is the tax on high-cost insurance plans, there is a health insurer fee, there is a Botox tax, which starts January 1 of 2010, and you can kind of go down the list. There are limits on FSAs, flexible spending accounts, which is something people use to put aside money so they can buy a high-deductible plan and have dollars available to deal with the incidental health care costs they have. So the taxes are going to go up on those. You can go through this whole list of taxes, all of which, as I said, are going to go into effect in the near term, but none of the benefits kick in until many years later.

Unfortunately for the American public, they are going to see the premium increases that will come as these taxes are imposed on all these various sectors of the health care economy and which will all be passed on to consumers in the form of higher premiums. So the American consumer—the American public, the taxpayers of this country—are going to see the costs immediately and won't see the benefits for 5 years. That is not fair. It is not the right way to set policy here in Washington, DC. It is much more transparent if we have these dates of the tax increases and the fees and the taxes in this bill sync'd up—synchronized, aligned—with the benefits when they begin so that everything starts at the same time.

So the motion to commit is, again, simply a motion to commit this back to the Finance Committee, and to create a level playing field where the revenues that are raised under the bill don't begin to kick in until the benefits start to kick in and the spending starts to kick in. That will give us the true picture, the actual picture of the cost which, as I said before, is $2.5 trillion over 10 years when it is fully implemented, and not the $1 trillion, or under $1 trillion that is being used by the other side. You have to look at the full picture over a 10-year period, when it is fully implemented. Obviously, that gives you a very different perspective about the overall true cost of this particular proposal.

The basic contours of this bill we have in front of us have not changed, nor do we expect them to change. They will tweak around with this government plan. There was already a vote on the issue of abortion, which I happen to believe taxpayer funds should not be used to finance. We have had that vote. There will be some other votes on individual aspects. But some of those things are not going to affect the fundamental core elements of this plan, which have stayed the same throughout the entire process. And those core elements are a massive expansion of Federal spending—$2.5 trillion over 10 years when it is fully implemented—massive cuts to Medicare—about $1 trillion over 10 years, when fully implemented, affecting hospitals, nursing homes, home health agencies, hospices, and beneficiaries of Medicare Advantage, of which there are about 11 million across the country—and it is also financed with increases in taxes, which I have mentioned. Those are the basic components of this bill. Seventy new government programs are called for. All the new spending, all the new bureaucracy, all the new taxes, and all the Medicare cuts, those things have not changed since this bill first started being debated several months ago.

That is where we are today. That is why I believe this is such a bad proposal for the future of this country. Because even after all that, if you look at the impact it has on premiums, according to the Congressional Budget Office, 90 percent of Americans end up the same or worse off. When I say the same, I mean year over year increases in their insurance premiums that are double the rate of inflation. So if you are buying in the small-group market today, or the large-group market, according to the Congressional Budget Office, you are going to see your insurance premiums continue to go up over time. If you buy in the individual market, you are going to see them continue to go up, but way more—a 10- to 13-percent increase in premiums for people who buy in the individual marketplace, above and beyond the rate of inflation that will impact people in the large- and small-group markets.

So the bottom line is, if you are looking for reform, if you are the average American citizen out there, the person I represent in South Dakota, who is hearing about health care reform, to them it means a couple of things. It means affordable access to health insurance for people across this country; and something that most of us—at least here on our side—think ought to be a part of this, and that is measures or proposals that actually bend the cost curve down rather than up. But what we have seen consistently throughout the course of this debate, with all the spending and all the tax increases and all the Medicare cuts, is no positive impact on premiums. The best that 90 percent of Americans can hope for is to maintain the status quo—stay where you are—which is double your increases year over year, double the rate of inflation in your health insurance premiums or, worse yet, increases of 10 to 13 percent above and beyond that. That is what 90 percent of Americans are looking at as a result of the health care reform proposal that is currently before the Senate.

There is a better way, and we believe the way to get this right is to start over and to actually focus on solutions that will drive down the cost of health insurance, that will bend that cost curve down, such as interstate competition, allowing pooling for small businesses, medical malpractice reform. We have a whole series of things that we think represent the consensus view of the people in this country. There is common ground we can all stand on. But regrettably, we have not been included in any of the discussions, nor have any of our ideas been a part of those discussions. Rather, they have chosen to pursue this course of a big spending program, with the higher taxes, and the Medicare cuts and the higher premiums.

I truly hope there will be support, as this process moves forward and we get onto the critical votes ahead of us, for a more rational step-by-step approach, doing this right, getting away from

this huge massive expansion of the Federal Government here in Washington, DC, and seriously focusing on solutions that actually do bend the cost curve down, that don't rely on these huge cuts to Medicare, that don't rely on these huge tax increases, but that actually find savings. And they can be achieved in the market by putting policies in place that will constrain costs and put downward pressure on the prices most people pay for health insurance in this country. It can be done. But it is going to require some boldness on the part of some of our colleagues on the other side.

I think our side is pretty well united. This is a bad policy, a bad prescription, if you will, for America's future. But we are going to need some help from a courageous Democrat or two to make sure this massive expansion of the Federal Government is defeated and that we can go back, start over, do this in a step-by-step way—the right way—and in a way that actually does lower costs for people in this country. I certainly think that is what my constituents in South Dakota expect, and I think that is what most Americans expect. They deserve to have health care reform that gives them that outcome—lower cost and access to affordable health care.

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

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

The legislative clerk proceeded to call the roll.

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

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

Mr. BROWNBACK. Mr. President, I ask for 10 minutes to be allotted to me under the minority time.

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

Mr. BROWNBACK. Mr. President, in the past few months this body has been forced to stand aside as Senator REID and a few others crafted a 2,000-page bill behind closed doors, the one we are on right now. Unfortunately, the product that was resolved at the closed-door meetings—at least the one we have now, I don't know about a future one—still raises taxes by $½ trillion. Probably under any new bill that comes out you are going to have taxes going up $½ trillion, cut Medicare by $½ trillion, raise premiums on American families, fail to bend the cost curve down, and expand government's encroachment further and further into people's health care decisions.

What I want to go through is a series of charts about how inflation is going to end up being the tax collector's best friend in this overall plan and how the tax of inflation is going to be one of the key features of how the overall bill is paid for.

I hope most people remember when we had inflation. A lot of people maybe don't remember when we had significant inflation. It is a cruel tax. It is a very cruel tax on people on fixed income, a very cruel tax on people in low-income status because constantly the dollars you have stay pretty stable, and everything you are buying goes up. So inflation kills you. It kills you in the pocketbook and is one of the things we have to be concerned about, particularly with the amount of money that is out in the money supply today and the likelihood of this moving forward and how it is built in to pay for this huge expansion that we can't afford in this bill.

I am joining my colleagues today in speaking against the $500 billion in new taxes that are in the Democrats' proposal to levy on the American people and the job-creating small businesses this is going to be put on, in an attempt to pay for this big 2,000-page bill.

This monstrous bill is flawed economic policy. I will develop that point for you as well. It fails to lower health care premiums, fails to bend the cost curve down, and will further cripple the struggling economy with massive and burdensome tax increases.

This careless legislation reminds me of a cautionary tale that is still being played out in another part of the world. That is what happened in the early 1990s in Japan. Japan, a surging economic giant at the time, suffered a severe economic recession in the early 1990s, of which the effects are still lingering even today in Japan.

During Japan's ''lost decade,'' from 1991 to 2003, their gross national product grew a paltry 1.4 percent annually, creating a decade of stagflation—that is where you have a stagnant overall growth but inflation in the economy—and limited economic growth. Most economists believe that Japan's economic recession would not have lasted nearly as long as it did had it not been for one fatal error that the Japanese government made. In the late 1990s, as their economy was recovering and appearing to be pulling out of its economic slump—so the economy is just getting going, starting to pull out of the economic slump—the Japanese government made a catastrophic decision to raise taxes. The result was that this one decision aborted the strong recovery the Japanese economy was starting to experience and plunged it back further into an economic downturn that lasted for many more years, the hangover from which is still on them today.

What are we doing here today, discussing a $2.5 trillion government entitlement expansion that raises taxes $½ trillion, plays budget gimmicks with our $12 trillion deficit and raises health premiums and costs for all Americans in the middle of the country's economic recession? What are we even talking about, why are we doing it? That is what I get from the people back home. They say why are you talking about this while are we in this recession? Why are you talking about this with the health care situation the way it is, to raise the cost, raise the insurance premiums, cutting Medicare when Medicare needs more, not money taken out of it? Now is not the time, this is not the bill, and this is not the way the American people want to see their health care reformed. What the American people want is for this body to lower health care costs and induce an economic recovery that creates jobs, not kills them, and grows the American economy, not thwarts it.

The way to do that is not to raise taxes, as is evidenced by what happened in Japan. Increased mandates, increased regulations, and increased taxes are a recipe for disaster. It is a recipe that kills jobs. In fact, President Obama's chief economic advisor, Dr. Christina Romer, stated earlier this year that as many as 5.5 million jobs could be lost due to the Democrats' new tax proposal in this 2000-page government takeover of health care. Nothing can be worse at a time when the Nation is already experiencing a 10-percent unemployment, a 26-year high. This bill will impose $28 billion in new taxes on employers that will ultimately be paid by American workers in the form of reduced wages and lost jobs.

Under this burdensome legislation employees will face stunted wages and the loss of their benefits as their employers attempt to find ways to fund these newly imposed mandates. As small businesses struggle to keep their doors open, tough decisions will have to be made on whether to raise prices, cut wages, or let go workers in order to find the funds necessary to comply with the Federal mandates imposed in this bill.

Furthermore, this bill will kill jobs by penalizing small businesses who are looking to grow—and small businesses are the growth engine for the country. In this bill, firms with more than 50 workers that did not offer coverage would have to pay a penalty or a tax to the Federal Government for each full-time worker if any of their workers obtain subsidized coverage through the government-run exchange.

What businessman would decide to hire that 50th employee, knowing full well if he did that the government would penalize his business and slam him with a new costly tax? So now people try to stay under this limit rather than constantly looking to grow the business.

Furthermore, under certain circumstances, firms with relatively few employees and relatively low average wages would be eligible for tax credits to cover portions of their health insurance premiums. That is relatively few would be eligible.

I ask, what employer would decide to increase the number of employees or increase the amount of their wages if they stand to lose government handouts, supports, subsidies, or face an increased tax burden? They simply will not be willing to do it.

One of the most disturbing aspects of this legislation is the use of inflation

to fund it—the use of inflation, a hidden tax increase on working families, to fund it.

I am the ranking member on the Joint Economic Committee and we look at these aspects a great deal. The use of inflation is built into the base of this to fund it. We know the consumer, the individual taxpayer, pays all taxes. No matter how the government claims to assess those taxes, they are paid by individuals.

I have a couple of examples I want to show. First, I want to talk about: High-cost Plans Tax Hits the Middle Class. Let me talk about that. This is the tax on the so-called Cadillac health insurance plans.

We know that insurance policies and benefit plans will be altered to avoid that tax. In other words, if you get an insurance plan that is up above a certain level you get taxed on that higher end, that so-called Cadillac plan. So in all probability most groups will not provide this high-quality health care because they say you are going to get taxed on it.

Benefits that taxpayers with insurance currently receive on a pretax basis—right now they get it so the company is paying for it, is pretax to the individual—will gradually shift to after-tax benefits resulting in higher payroll and income taxes. So now that you have cut this Cadillac plan to get underneath it being taxed, and then the company says OK, we will pay you in wages or we will do this somewhat differently. Then you have to go around and supplement or have a lower quality of health insurance. You are going to have to pay for it with after-tax dollars. That will result in more taxes, but you don't get more benefits from this. This is a big tax hit on the middle class of people who are going to have to pay this as their higher income or their higher based insurance plans are taxed.

Here is what the Joint Committee on Taxation said about the distribution impact of the high-cost tax plans: Despite the President's promises the majority claims—91 percent of taxpayers will be affected by this tax earning under $200,000. The tax will hit married filers more severely than singles; 62 percent of the high-cost plans tax impact will fall on married filers compared to 25 percent on single filers. Why are we building the marriage penalty back into the insurance? We worked a long time in this body to get rid of key portions of the marriage penalty, saying we should not tax marriage, we should support this institution. It is being built back into this plan.

This bill also imposes an additional Medicare tax on wage and salary—or certain types of business incomes of single taxpayers with incomes above $200,000 and married taxpayers with incomes of more than $250,000. Right off the bat there is a new marriage penalty. People living together but unmarried making $150,000 each won't pay the tax. Two married people paying the same amount will. What is right about that?

Making matters worse, the thresholds are not indexed for inflation—no indexing for inflation. Inflation is a cruel tax and unfortunately in this situation it is not only going to be inflation, but you are going to be taxed, then, as you get inflated into these categories. From 2013 to 2019, the number of returns of people earning under $200,000 in today's dollars will rise from 75,000 to 345,000 under the current trajectory on inflation. We are making the tax man's best friend inflation. That is wrong. So you are going to move 75,000 to 345,000 for new tax revenue. Married couples will be hit hard, as I mentioned earlier. Then you are looking at inflation: 2013, 2015, 2017, 2019—the number of people growing into this taxable category affected by this Medicare tax that will increase in 2009 dollars from $75,000 to $345,000.

If you want to think about this, think about when the alternative minimum tax was first put in place. The alternative minimum tax was supposed to be on very wealthy individuals. That was all it was going to be on. But it was not indexed for inflation. Now you get whole swatches of people hit by it and this body regularly tries to change that or deal with it on a 1-year basis because it was not indexed for inflation. What you build into the base of this bill is, if you want to pay for the bill, you want inflation. So you get inflation and it hurts people on fixed incomes and you get more people taxed than you started off with. You didn't tell them about it at the outset.

This plan clearly should be indexed for inflation. We know that should take place. Yet this is where a major part of the money for the bill comes from—inflation. Is that something the Federal Government should be banking on, that we will get inflation to pay for this health care bill? I don't think the American public wants to see that taking place.

To put this in context, let's not just look at returns under $200,000, let's look at all returns and how this tax will spread. According to the Census Bureau estimates, between 2013 and 2019, the working-age population of the country will grow by 1.6 percent. Joint Tax estimates that the number of returns that will be affected by this tax will grow by 52.6 percent and revenue collected as a result of the tax will grow by more than 54 percent. Over time, the Reid bill Medicare tax isn't just for the wealthy. Comparing the increase in taxes with growth in the working-age population, this is how many more people will be impacted. Inflation becomes the tax man's key friend.

During Japan's lost decade, from 1991 to 2003, their gross national product grew a paltry 1.4 percent annually, creating a decade of stagflation and limited economic growth. It was because of policies such as this where you have inflation, where you have tax increases put in place. These are the things that caused that to take place. It should not be done.

I will just add as a final note, when I am talking with people back home, all the time they raise this health care bill. They talk about it constantly. If they are small businesspeople, they are talking about not doing anything until the political environment is more stable in their estimation, about how much taxes we are talking about, about how much regulation we will be talking about.

You have what is going on with a climate change debate and regulations in Copenhagen. That tells a lot of people in my area who are energy users and producers, don't do anything until this stabilizes. When you talk about tax increases or inflation being a part of this proposal, you have a bunch of people saying: Don't do anything. Just stay on the sideline. That is a prescription for no job growth. That is a prescription for killing jobs. You want people out there investing and creating jobs and opportunities. You want them to see a stable political environment where they are not worried about increasing taxes, not worried about increasing regulation but, rather, saying: This is a stable environment in which we can invest and grow. That is not what they are doing today. That is repeating the lesson the Japanese learned of raising taxes when you are coming out of a recession. It is harmful. It is the wrong economic strategy. It should not be a part of this bill.

I yield the floor.

Mr. ENZI. Mr. President, I voted to support Senator MCCAIN's motion to commit the bill back to the Finance Committee to protect all seniors from the Medicare cuts in this bill.

Section 3201(g) of the Reid bill shields Florida from the sweeping payment reductions to Medicare Advantage plans. Democratic Senators from Florida, New York, Oregon and Pennsylvania have also reportedly sought carve outs to protect seniors in their States from these cuts.

It is unfair to protect only seniors in Florida from these cuts. President Obama said if you like what you have, you can keep it. I believe that principle should apply to all Medicare beneficiaries.

At least some of my Democratic colleagues are honest about what they are doing. The New York Times yesterday quoted the Senator from Florida as saying, ''It would be intolerable to ask senior citizens to give up substantial health benefits they are enjoying under Medicare . . . I am offering an amendment to shield seniors from those benefit cuts.''

Bloomberg News also quoted that same Senator as saying, ''We're trying to grandfather in seniors so that they don't lose the benefits they have.''

Now, I disagree with these sweetheart deals. But I understand the motivation behind them. We should not be

taking benefits away from Medicare beneficiaries.

What I don't understand is how other Democrats can deny that the Reid bill cuts Medicare benefits. I have heard my Democratic colleagues repeatedly argue that there no cuts of any ''guaranteed benefits'' in the Reid bill.

I was not familiar with the term ''guaranteed benefits,'' so I asked my staff to review the Medicare statute. They searched through the entire Social Security Act, which governs Medicare, and could not find that term anywhere. That is because the term doesn't exist. The other side just made it up.

Medicare Advantage plans provide extra benefits to beneficiaries who enroll in these plans. These are the benefits that will be cut under the Reid bill. Clearly the Senator from Florida understands the value of these benefits. That is why he and other Democrats are fighting tooth and nail to undo the cuts in their States.

At the same time, other Democratic Senators continue to argue that Medicare Advantage is neither Medicare nor an advantage.

That is false. Medicare Advantage is Part C of Medicare. If you go to the Web site of the Department of Health and Human Services, it says Medicare Advantage is part of Medicare.

As to the ''advantage'' part, Medicare Advantage does provide extra benefits, and seniors place great value on them. It's that simple. That is why the Senator from Florida and others are trying to get carve outs for seniors in their States.

Under the Reid bill, seniors will lose vision benefits. Apparently, the other side does not think vision care is an advantage.

The Reid bill will cut dental benefits for seniors. These are also apparently not an advantage for seniors.

The Reid bill will cut hearing benefits for seniors. These are apparently not an advantage for seniors.

The Reid bill will cut home care for seniors with chronic illnesses. The other side thinks these benefits are not an advantage.

The Reid bill will cut disease management programs for seniors. These benefits are also apparently not an advantage.

The Reid bill will cut nurse help hotlines for seniors. The majority apparently does not believe this is an advantage.

The Reid bill will end reduced cost sharing for primary care physician visits. This is apparently not an advantage for seniors.

The Reid bill will eliminate reduced premiums for Part B. This is apparently not an advantage for seniors.

The Reid bill will eliminate reduced cost sharing for breast cancer screening. This is apparently not an advantage for seniors.

The Reid bill will eliminate reduced cost sharing for prostate cancer screening. This is apparently not an advantage for seniors.

Most disturbing of all, the Reid bill will cut seniors' protections against catastrophic costs under Medicare Advantage. The other side says they want to keep medical bills from driving folks into bankruptcy. At the same time, they are eliminating Medicare Advantage benefits that actually protect Medicare beneficiaries from catastrophic medical costs.

How is catastrophic coverage not an advantage to seniors? It seems to me few things could be more advantageous than not losing your life savings because of medical bills.

It is obvious to anyone who listened to the list I just read that these are real benefits. Furthermore, it should be equally clear that the Reid bill will take these benefits away from millions of Medicare beneficiaries.

Anyone who doubts what affect the Reid bill will have on Medicare beneficiaries should look at the last time that Congress made cuts like this. The impact was severe.

Congress enacted the Balanced Budget Act of 1997, which included similar types of cuts. Once it took effect, nearly one out of every four of the plans, then known as Medicare+Choice, pulled out of the program.

According to an article in the Fort Lauderdale Sun Sentinel, when the Prudential Medicare+Choice plan withdrew from Florida, nearly 12,000 seniors in Broward, Palm Beach and Miami-Dade lost their coverage of prescription drugs, eyeglasses, hearing aids or other benefits.

You can bet seniors in Broward, Palm Beach and Broward counties haven't forgotten these cuts, losing their plans, sometimes their doctors, and certainly those benefits.

According to the Baton Rouge Advocate, over 50,000 Louisiana seniors lost the extra benefits that had been provided by Medicare+Choice plans. The cuts were so disruptive and confusing that State Insurance Commissioner Jim Brown had to air public service announcements. You can bet Louisiana seniors remember those cuts.

After these cuts went into effect, the Chicago Daily Herald reported that the Senior Health Insurance Program run by the Illinois Department of Insurance was ''deluged with phone calls from senior citizens affected by the move of some health maintenance organizations to drop Medicare.''

By that time, United Healthcare had decided to no longer offer Medicare+Choice plans in DuPage, Kane, Lake and Will counties. This affected 12,000 seniors in these Chicago suburbs.

By 2000, the Daily Herald reported that Aetna and Humana were also pulling out, dropping coverage for 2,794 beneficiaries in Lake County and 6,180 Aetna enrollees in Cook, Lake, Kane and DuPage counties. All of these beneficiaries lost the extra benefits they had previously received from their plans.

Brian Carey, director of Senior Services for Schaumburg Township, was quoted as saying, ''It's just thrown so many people into, in some cases, a complete state of panic.''

By 2002, the Chicago Tribune quoted CMS administrator Tom Scully as saying there were no—that's zero—Medicare plans serving Chicago and its suburbs.

If the Reid bill is passed, we will again see millions of Medicare beneficiaries lose the benefits they currently receive from Medicare Advantage.

Medicare beneficiaries understand this program provides real advantages to those who enroll in the program. They do not want to lose these benefits.

I hope that all of my colleagues support the McCain amendment and ensure that these seniors continue to receive these benefits.

Mr. JOHNSON. Mr. President, today I rise to recognize the overwhelming need for health care reform. Earlier this year I asked South Dakotans to share their personal health care stories with me, the good and the bad, so that I could share these with my colleagues and ensure that the people of South Dakota have a voice in this national debate. Thousands have responded to my request and through their stories I have gained immeasurable insight into the challenges my constituents face in our current health care system. The experiences of these hard working families, business leaders, patient advocates, and health care providers poignantly demonstrate the urgent need for health care reform.

David, a farmer in Madison, SD, was forced to sell his land when a heart attack left him with $60,000 in medical bills. His wife Patty wrote to me to tell me his story. As a farmer, David couldn't afford to buy private health insurance in the individual market but didn't qualify for public programs. Insurance companies refused him coverage after his heart attack because he now had a serious preexisting condition. Last year he suffered a second heart attack and accrued another $100,000 in medical bills. Struggling to pay this debt, Patty and David exhausted all their resources. David feels he has no hope of finding insurance coverage for his heart health, the very condition that requires treatment the most. Patty and David live in fear of a serious illness knowing that, like many families, adequate health insurance is beyond their reach.

The situation Patty and David find themselves in is not unique. A recent study by the Access Project found that 44 percent of ranchers and farmers in South Dakota get their health insurance on the nongroup market, where they pay on average $10,395 for coverage. For the past few decades, premium rates have been rapidly outpacing increases in incomes. According to the study, almost half of those surveyed spent over 10 percent of their income on health care. Like Patty and David, one in four of the farmers and

ranchers surveyed had to dip into savings, retirement funds, or take loans against their farms or ranches to cover health care costs.

Managing heart disease requires regular checkups and treatments to manage the disease, improve overall health and prevent future complications. Without access to these services, Patty fears what will happen to their family and their farm in the event David suffers another heart attack.

There are several provisions in the Patient Protection and Affordable Care Act to benefit Americans like Patty and David. It will extend access to affordable and meaningful health insurance for all Americans. The bill stands up on behalf of the American people and puts an end to insurance industry abuses that have denied coverage to hardworking Americans when they need it most. According to the non-partisan Congressional Budget Office, the Senate reform proposal will extend coverage to 31 million more Americans when fully enacted.

Immediately after enactment, a new program will be created to provide affordable coverage to Americans with preexisting conditions who have been denied the coverage they need. People like David will be guaranteed health insurance coverage after years of struggling without this basic security.

In addition, this legislation will create health insurance exchanges in every State through which those limited to the individual market will have access to affordable and meaningful coverage. The exchange will provide easy-to-understand information on various health insurance plans, help people find the right coverage to meet their needs, and provide tax credits to significantly reduce the cost of purchasing that coverage. No matter what plan you have, every American will have the added security of knowing that your insurance company will no longer be able to deny coverage for preexisting conditions and won't be able to drop your coverage if you get sick. Patty, David, and all Americans deserve this basic security.

The PRESIDING OFFICER. The Senator from Montana.

MORNING BUSINESS

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

CLIMATE CHANGE

Mr. CARDIN. Mr. President, we live in a world that is being poisoned by greenhouse gases of our own making. If we do not act, we face irreversible, catastrophic climate change. My grandchildren face a world where there will be not enough food, water, or fuel, a world that is less diverse, less beautiful, less secure. As I speak today, we are witnessing a critical moment in our fight against global warming both at home and abroad.

This past Monday, the Environmental Protection Agency acted by releasing its final determination that ''greenhouse gases threaten the public health and welfare of the American people.'' This was an action required by law and ordered by the Supreme Court. This finding will require EPA regulate greenhouse gas emissions under the Clean Air Act.

Monday's endangerment finding is a critical step in our country's efforts to stop global warming, which not only poses a threat to public health and welfare but to our national security. I am proud of the strong science-based actions taken by this administration to live up to its Clean Air Act obligations to protect our health. But I strongly believe that the best way for our country to solve the problem of greenhouse gas emissions is through comprehensive legislation enacted in the Congress of the United States. Legislation that invests in clean energy and new, high-tech infrastructure will bring us to long-sought goals: energy independence, good jobs for our citizens, and a healthy planet for our children and grandchildren.

We are now closer to that kind of legislation than we have ever been. The House has passed a bill that puts a limit on the pollution in our air. It dedicates funding to develop new domestic sources of clean energy. It invests in a new infrastructure that is less dependent on foreign fuels and creates American jobs. And we need those jobs. Here in the Senate, we have improved on our colleagues' work. Senate legislation makes additional investments in clean transportation. It provides additional oversight and accountability and support for developing countries. It ensures we do not add one penny to our national deficit. This legislation is consistent with the budget of our country to try to help reduce the deficit and yet make us energy independent, create jobs, and be sensitive to our environment.

But because climate change is a global problem, we need a global solution. This past Monday was also an important day in the international effort. The international community began a 2-week meeting in Copenhagen, Denmark, to work on an international agreement to address climate change.

The international community has set the right objectives to make the meeting a success: a political agreement that promises both immediate action and contains the structure for a future formal treaty.

The agreement reached in Copenhagen should include the following points: specific near-term greenhouse gas emission reduction targets—a critical part—the support the developed countries will provide to the developing world to adapt to a changing industrial economy and a changing climate—we have a responsibility to help the developing world—the core elements that will make up the final treaty; and a timeline for reaching that agreement within the next year. We cannot put this off. It is critical we act timely.

The administration has taken several very important actions over the past few weeks to help us secure a global agreement in Copenhagen. EPA's endangerment finding sends an important signal to the world about the United States commitment to take decisive action.

Similarly, the President's announcement that the United States will commit to an emissions reduction in the range of 17 percent below 2005 levels by 2020 and his pledge to contribute the fair share of the United States of $10 billion a year in financial support for the developing world by 2012 demonstrate that we are prepared to be serious partners in the fight against climate change.

That is the type of action we want to see, not only in the United States but in other countries that are major emitters.

Many of my colleagues, however, have legitimate concerns that if the United States enacts strong carbon standards, carbon-intense imports will have an unfair advantage in our market. We need to make sure we accomplish our goals internationally and also have a level playing field.

To address this fear, I believe it is critical that our international negotiators include in Copenhagen strong verification and compliance procedures that will make it clear that every state has a responsibility to take action to reduce greenhouse gases.

I have seen too many international agreements that include the highest ambitions for labor, environmental, and human rights protections that fail to achieve those goals in the absence of any consequences for violations of those principles.

The groundwork for achieving a final international agreement in Copenhagen must ensure that major emitting Nations take on clearly defined emissions reductions targets, adopt standardized systems to measure, report, and verify actions and commitments, and it must provide for consequences if countries fail to meet those commitments. Inclusion of these principles in the Copenhagen agreement allows us to pursue these critical components in any final agreement, and sends an important signal that all party countries are committed to real emissions reductions.

I am proud that the Senate Foreign Relations Committee climate change bill introduced by Senator KERRY last week includes language I authored that makes clear our expectations that any international agreement should include strong verification and compliance mechanisms, along with emission reduction targets, and a strong commitment to provide assistance to the developing world.

I will be watching the negotiations and hope it will produce the kind of agreement I have discussed here today. But regardless of what Copenhagen brings, I will continue to advocate for domestic legislation that invests in clean, domestic energy, and frees us from energy policies that undermine our national security and our economy by being dependent upon imported oil.

I will advocate for legislation that invests in the industries of tomorrow to stem the loss of clean energy jobs—jobs that stem from American inventions and ideas—to countries overseas. I will advocate for legislation that provides significant investment in clean fuels and public transit, so we seize an opportunity to build the infrastructure of tomorrow and change the way we move people and goods around this country. Right now, the transportation sector represents 30 percent of our greenhouse gas emissions and 70 percent of our oil use. If we could only double the number of transit riders every day, we could reduce our dependence on foreign oil by 40 percent. That is equivalent to the amount of oil we import every year from Saudi Arabia.

That kind of legislation is good for our country and good for Maryland. But we must remember that even after Copenhagen, any deals we reach, any papers we sign, are still but the foundation. The work must continue with earnest followthrough, dedicated to truly changing the way we work and live and move around this Earth.

OSCE MINISTERIAL MEETING

Mr. CARDIN. Mr. President, last week the Organization for Security and Cooperation in Europe, OSCE, held its annual Ministerial Meeting in Athens. As always, the OSCE Parliamentary Assembly was strongly represented there. Today, in my capacity as Chairman of the Commission on Security and Cooperation in Europe, I would like to offer a few reflections on the outcome of the meeting, and what this might mean for the future of European security, in which the U.S. has a vital stake.

Each year, a different country serves as the OSCE's ''Chairman in Office.'' This year, Greece was the Chairman-in-Office and this year's Ministerial Council meeting subsequently took place in Athens. In recent years discord and paralysis have increasingly begun to overwhelm the cooperation and consensus that once characterized the OSCE. The Greeks thus began their chairmanship facing a difficult challenge.

At last year's meeting in Helsinki under Finland's able chairmanship, the Ministers decided that the OSCE should look for ways to overcome this gridlock and to give the organization a new impetus. Greece took this task to heart and launched the ''Corfu Process'' to do just that. This effort has already borne fruit. In Athens, the ministers resolved to continue to try to reaffirm, review, and reinvigorate security in the OSCE region by continuing this process.

The Ministers also agreed on decisions that addressed such fundamental and persistent problems as hate crimes, tolerance and nondiscrimination, nonproliferation, terrorism, and the ''protracted conflict'' in Nagorno-Karabakh. One of these decisions, on countering transnational threats, was sponsored by the U.S. and Russia, the first such joint effort in several years. I hope this is a positive portent for the future.

The Ministers were not able to agree on how to tackle some other equally important and pressing problems. These included the protracted conflicts in Georgia and Moldova, OSCE assistance to Afghanistan, and the Conventional Forces in Europe Treaty. Clearly, much work remains to be done in putting the OSCE fully back on track.

I would be remiss if I concluded my remarks without commending the Greek chairmanship for its untiring and ultimately successful efforts during the course of this year. The chairmanship rekindled the trust and confidence among the participating states that had steadily eroded over the past decade. Greece has clearly set the stage for a brighter and more productive future for the organization, and my colleagues on the Helsinki Commission, and I would like to congratulate the Greek chairmanship on this significant accomplishment.

We would also like to wish Kazakhstan, the first Central Asian nation to hold this office, every success in its historic chairmanship in 2010 and to offer them our full support. Indeed, in our view the Kazakh chairmanship is already off to a promising start, for in Athens, at the initiative of the Kazakhs, the Ministers decided to hold a high-level conference on tolerance next year. This proved to be a timely decision, coming as it did just as Switzerland voted to ban the construction of Muslim minarets, and the president of the Swiss Christian Peoples Party called for a ban on Muslim and Jewish cemeteries. These actions reminded us that not even countries that have played a leading role in establishing international human rights standards are immune from the tendencies to discriminate against immigrants and minorities and to place limits on the free expression of religious beliefs.

It is very important for the OSCE to combat these troublesome trends. It is also important that all the organization's participating states reaffirm, and commit themselves to upholding, the rights of all religious communities to create places of worship and to rest in line with their own traditions. I very much hope the OSCE's conference on tolerance next year will advance this effort.

Finally, let me say that we look forward with great interest to the forthcoming discussions of Kazakhstan's proposal to hold a meeting of heads of state and government during its chairmanship. Should it happen, this would be the first such ''summit'' under OSCE auspices, something that was previously a regular occurrence. In Athens, in acceding to this proposal, the United States expressed the view that it is open to considering such a meeting if, but only if, such a summit can produce results of substance. I think this is the correct approach, and it is one I fully support.

EDUCATION TAX INCENTIVES

Mr. GRASSLEY. Mr. President, yesterday I offered legislation to make permanent a number of education-related tax relief measures. My legislation, S. 2851, also improves and makes permanent helpful provisions for 529 plans and the American opportunity tax credit for education.

At the first hearing I held when I became chairman of the Finance Committee in 2001, I made clear that education tax policy was a priority of mine. As chairman, I was able to remove the 60-payment limit for deducting student loan interest and I was able to increase the income limits for that deduction. This was not the only time I fought hard to allow students to deduct their student loan interest. In 1997 I was able to reinstate the student loan interest deduction that Congress had eliminated from our tax laws. However, the 60-payment limit on the deductibility of student loan interest remained. I ensured that the 2001 tax relief bill took care of that problem. Other incentives for education that I was able to enact into law in 2001 included raising the amount that can be contributed to an education saving account from $500 to $2,000; making distributions from prepaid college savings plans and tuition plans tax-free; and making permanent the tax-free treatment of employer-provided educational assistance. These tax policies and many others, including those for school renovations, repairs and construction, have proven their value to Iowa students in dollars and cents, year after year. The tax relief has delivered measureable educational assistance to Iowans and students and families nationwide, making education more affordable and accessible.

One drawback of enacting these provisions in the 2001 tax relief bill, however, is that there was a sunset provision attached to that entire piece of legislation. All of the tax relief needs to be made permanent. Especially the education-related tax provisions. And that is what my bill today does. My bill makes these provisions permanent.

It is no coincidence that I introduced my education tax bill on the day the President of the United States talked about jobs. Our economy demands well-educated workers. The popularity of education tax incentives is good news for workers who find themselves unemployed or who want to go back to school to advance, or even change,

their careers. Congress is willing to consider permanent tax relief for companies to buy machinery. Why isn't Congress willing to make an investment in people? That's what tax relief for education is. An investment in our future. It is just as important as job-creating tax incentives for businesses. Some will say we can't afford this, but we really can't afford to lose billions of dollars of help for Americans working hard to educate their kids.

Education has made this country great. We should not let this opportunity pass us by. We should not let these education-related tax provisions expire. We should also continue to help make education affordable for families and students. This makes education accessible for all. I look forward to working with my colleagues on passing this bill.

PENDING NOMINATIONS

Mr. LEAHY. Mr. President, last week, I challenged Senate Republicans to do as well as Senate Democrats did in December 2001 when we proceeded to confirm 10 of President Bush's Federal judicial nominees. Regrettably my plea has been ignored. Since the confirmation of Judge Jacqueline Nguyen last Tuesday to fill a vacancy on the Federal bench for the Central District of California; Republican objections and delay have prevented progress on any of the nine judicial nominees pending on the Senate Executive Calendar. Judge Nguyen was herself delayed almost 6 weeks, from October 15 until she was at last confirmed on December 1. When Republicans finally agreed to allow a vote, she was confirmed unanimously, 97 to zero. Why the 6-week delay? Why the stalling? That question was not answered. In fact, during the time reserved for debate on this nomination no Republican spoke a word about it.

I know how hard pressed the Federal judges in Los Angeles are, and only wish we followed the action on Judge Nguyen's nomination by proceeding, as well, to the confirmation of another nominee for a vacancy on that court. Dolly Gee's nomination to the Central District of California remains pending before the Senate. She was reported by voice vote and without dissent from the Senate Judiciary Committee on October 15, as well. Once confirmed, she will be able to go to work helping to eliminate the backlog and delays in that court.

I was glad we were finally allowed to proceed with Judge Nguyen's nomination, but urged at that time that Senate Republicans allow votes on the other nominations as well. That has not happened. I noted that we had shown what we can do when we want to make progress. The Senate confirmed Judge Christina Reiss of Vermont and Judge Abdul Kallon of Alabama before the Thanksgiving recess, and 17 days after their hearing. That prompt action by the Senate demonstrates what we can do working together in good faith. It should not take weeks for the Judiciary Committee to report nominations, and additional weeks and months before Senate Republicans allow nominations to be considered by the Senate.

There remain nine judicial nominations that have been given hearings and favorable consideration by the Senate Judiciary Committee but that remain stalled before the Senate. They are: Beverly Martin of Georgia, nominated to the Eleventh Circuit; Joseph Greenaway of New Jersey, nominated to the Third Circuit; Edward Chen, nominated to the Northern District of California; Dolly Gee, nominated to the Central District of California; Richard Seeborg, nominated to the Northern District of California; Barbara Keenan of Virginia, nominated to the Fourth Circuit; Jane Stranch of Tennessee, nominated to the Sixth Circuit; Thomas Vanaskie of Pennsylvania, nominated to the Third Circuit; and Louis Butler, nominated to Western District of Wisconsin. These nine nominees all await final action by the Senate. Some have been waiting since being reported by the Senate Judiciary Committee as long as 12 weeks ago.

Acting on these nominations, we can confirm 10 nominees this month. That is what we did in December 2001 when a Democratic Senate majority proceeded to confirm 10 of President Bush's nominees, and ended that year having confirmed 28 new judges nominated by a President of the other party. We achieved those results with a controversial and confrontational Republican President after a mid-year change to a Democratic majority in the Senate. We did so in spite of the attacks of September 11; despite the anthrax-laced letters sent to the Senate that closed our offices; and while working virtually around the clock on the PATRIOT Act for 6 weeks.

It is now December 9 and the Republican minority has consented to allow votes on only nine of President Obama's nominations to fill district and circuit court vacancies. We confirmed a tenth, Judge David Hamilton, after invoking cloture to overcome a Republican leadership-led filibuster. In comparison, by this date in 2001, we had confirmed 21 of President Bush's nominations, including six to fill circuit court vacancies. We will certainly fall well short of the total of 28 judicial confirmations our Democratic Senate majority worked to confirm in President Bush's first year in office.

This year we have witnessed unprecedented delays in the consideration of qualified and noncontroversial nominations. We have had to waste weeks seeking time agreements in order to consider nominations that were then confirmed unanimously. Judge Nguyen is the most recent example. We have seen nominees strongly supported by their home state Senators, both Republican and Democratic, delayed for months and unsuccessfully filibustered. I have been concerned that these actions by the Republican leadership signal a return to their practices in the 1990s, which resulted in more than doubling circuit court vacancies and led to the pocket filibuster of more than 60 of President Clinton's nominees. The crisis they created eventually led even to public criticism of their actions by Chief Justice Rehnquist during those years.

I hope that instead of withholding consent and threatening filibusters of President Obama's judicial nominees, Senate Republicans will treat the nominees of President Obama fairly. I made sure that we treated President Bush's nominees more fairly than President Clinton's nominees had been treated. In the 17 months that I served as chairman of the Senate Judiciary Committee during President Bush's first term, the Senate confirmed 100 of his judicial nominations.

I want to continue that progress, but we need Republican cooperation to do so. I urge them to turn away from their partisanship and begin to work with the President and the Senate majority leader.

Unlike his predecessor, President Obama has reached out, reached across the aisle to work with Republican Senators in making judicial nominations. The nomination of Judge Hamilton, which the Republican leadership filibustered, was supported by the most senior Republican in the U.S. Senate, my respected friend from Indiana, Senator LUGAR. Other examples are the recently confirmed nominees to vacancies in Alabama supported by Senators SESSIONS and SHELBY, in South Dakota supported by Senator THUNE, and in Florida, supported by Senators MARTINEZ and LAMIEUX. Still others are the President's nomination to the 11th Circuit from Georgia, supported by Senators ISAKSON and CHAMBLISS, his nomination to the 6th Circuit from Tennessee, supported by Senator ALEXANDER, and his recent nominations to the 4th Circuit from North Carolina, supported by Senator BURR. President Obama has reached out and consulted with home State Senators from both sides of the aisle regarding his judicial nominees.

Instead of praising the President for consulting with Republican Senators, the Republican leadership has doubled back on what they demanded when a Republican was in the White House. No more do they talk about each nominee being entitled to an up-or-down vote. That position is abandoned and forgotten. Instead, they now seek to filibuster and delay judicial nominations. They have also walked back from their position at the start of this Congress, when they threatened to filibuster nominees on which home state Senators were not consulted. We saw with Judge Hamilton that they filibustered a nominee supported by Senator LUGAR.

When President Bush worked with Senators across the aisle, I praised him

and expedited consideration of his nominees. When President Obama reaches across the aisle, the Senate Republican leadership delays and obstructs his qualified nominees. I fear that Senate Republican delaying tactics will yield the lowest judicial confirmation total in modern history. If Senate Republicans continue their delaying tactics, the total could be as low as that during the 1996 session, during President Clinton's first term, when a Republican Senate majority would only allow 17 judicial confirmations, none for circuit courts.

Although there have been nearly 110 judicial vacancies this year on our Federal circuit and district courts around the country, only 10 vacancies have been filled. That is wrong. The American people deserve better. As I have noted, there are nine more qualified judicial nominations awaiting Senate action on the Senate Executive Calendar. In addition there are another four pending before the Senate Judiciary Committee that have been given hearings and could be reported to the Senate before Christmas. They will be available to be considered by the Senate once approved by the Judiciary Committee. The Senate should do better, and could if Senate Republicans would remove their holds and stop the delaying tactics.

During President Bush's last year in office, we reduced judicial vacancies to as low as 34, even though it was a Presidential election year. Judicial vacancies have now spiked. There are currently 97 vacancies on our Federal circuit and district courts, and 23 more have already been announced. This is approaching record levels. I know we can do better. Justice should not be delayed or denied to any American because of overburdened courts and the lack of Federal judges.

REMEMBERING ABE POLLIN

Ms. MIKULSKI. Mr. President, I rise to pay tribute to the life and legacy of my friend Abe Pollin. He was a businessman, community leader, philanthropist, familyman. He was someone who simply made our community and our Nation a better place.

Abe was a great man who did great things. But he did it without a lot of fanfare. He was a team owner who thought first about the community that supported his teams. He was an employer who didn't treat his athletes or his employees as commodities—but as members of his team.

Abe Pollin was also a developer. But he didn't just invest in buildings, he invested in communities. He built one of the first big apartment buildings in Bethesda, named after his beloved wife Irene, long before Bethesda became the vibrant downtown that it is today. He never lost faith in Washington—building the MCI Center, now the Verizon Center, in the mid 1990s—which led to the revival of downtown Washington.

Here in the DC Metro area, there are few community organizations that did not benefit from his advice, his philanthropy or his leadership. Abe made our region a better place, and will be greatly missed.

My thoughts and prayers are with the Pollin family—his wife Irene, who is a founding mother of the effort to empower women to fight heart disease, and his children and grandchildren. I will be forever grateful for the Pollin family's early support of a young city council woman from Baltimore who wanted to run for Congress. Abe Pollin was one of my earliest supporters, and his faith in me meant a great deal.

Last night, thousands of people gathered at the Verizon Center to celebrate Abe Pollin's life. His legacy is a community that is stronger, more vibrant—and simply a better place to live.

SOMALIA

Mr. BROWNBACK. Mr. President, I rise to speak about the recent suicide bombing in Somalia and the broader security situation in that region. While our attention is necessarily focused on the wars in Afghanistan and Iraq, this latest bombing is a stark reminder that we cannot take our eye off of the Horn of Africa.

Last week, Somalis had a reason to celebrate. The graduation of several medical students from a university in Mogadishu was a welcome glimmer of hope for the future. Unfortunately, a suicide bomber intruded, blew himself up, and killed more than 20 others, including three Ministers from the fledgling Somali transitional government. There is, seemingly, no end to the violence which has plagued Somalia for a generation.

Somalia continues to lack a truly functional government, and for several years, we have watched the slow but steady development of extremism there. Though we support the development of a moderate government for Somalia, success is far from assured. The transitional government lacks control of significant parts of the country and struggles to provide the most basic services to the Somali people.

The most significant challenge to the transitional government comes from extremist groups such as al-Shabab, a group of Islamist terrorists with deep roots in Somalia that came to prominence after the defeat of the Islamic Courts Union 3 years ago. As we have seen throughout the world, if there is a power vacuum, violent extremists will seek to fill it, and that is what is taking place in Somalia. Somalia cannot succeed while groups such as al-Shabab grow and thrive.

Al-Shabab's future depends in no small part on support from outside the country. Al-Shabab gets new recruits from all over the world, it is strengthening ties to al-Qaida and the global jihadist network, it receives support from regional actors such as Eritrea, who use al-Shabab as a proxy for its own interests. Al-Shabab will not be defeated while this outside support continues.

For this reason, I hope that our administration will work hard to support and pass a draft resolution now circulating at the United Nations Security Council. Uganda, one of the Council's current rotating members, has drafted a resolution that addresses Eritrean support for Somali extremist groups, including al-Shabab. The resolution, which follows strong warnings to Eritrea from the U.S. and the African Union not to support al-Shabab, would ban weapon sales to Asmara, prohibit technical, financial and other assistance related to military activities, and freeze the assets of Eritrean political and military leaders as well as restrict their travel.

Al-Shabab seeks to undermine any attempt to stabilize Somalia. A volatile Somalia jeopardizes the stability of the Horn of Africa region, which is itself important to security in Africa, the greater Middle East, and the rest of the world. Support for extremist groups such as al-Shabab is unacceptable, and as long as Eritrea provides arms to al-Shabab, there will be no chance for peace in Somalia. I hope that the Security Council can take up and pass this resolution soon, and I hope the United States will be a strong supporter of this effort. Somalia ought not be a safe haven for extremists or a playground for outside powers pursuing their own agendas. Though Somalia's future is far from clear, the Security Council should have no difficulty in agreeing on the need to take steps to cut al-Shabab's lifelines of outside support.

TRIBUTE TO VIDA CHAN LIN

Mr. ENSIGN. Mr. President, today I commemorate the beginning of an exciting chapter for the Las Vegas Asian Chamber of Commerce. For more than 20 years, this group of entrepreneurial southern Nevadans has worked together to provide resources and promote economic growth in the Asian community. Today, they will install the first woman to be president of their esteemed organization. Vida Chan Lin steps into this role—respected by her peers and energized by her passion for furthering the goals of the Las Vegas Asian Chamber of Commerce.

While this leadership role is a new opportunity for Ms. Lin, her lifetime of experience has prepared her to take on this role. As a child, she was exposed to running a business as she saw firsthand the daily challenges and joys in the restaurants her family owned. She then found great satisfaction in the insurance industry where she continued to exceed expectations and eventually start her own company.

Ms. Lin has always balanced her business drive and success with her commitment to community service. She has been an instrumental force behind the Las Vegas Asian Chamber of Commerce for many years. Her ability

to bring people together, develop innovative programming, and mentor young leaders has helped ensure the long-term success of the Asian Chamber well beyond just her tenure.

She has been recognized by countless organizations for her business acumen and her heartfelt commitment to public service. I am proud to congratulate Vida Lin on this special day, and I wish her great success in the coming term of her presidency.

ADDITIONAL STATEMENTS

RECOGNIZING WHITNEY WREATH

• Ms. SNOWE. Mr. President, one of the great symbols of the winter holiday season we are just beginning is the wreath. Between the beautiful green needles and the fragrant smell, wreaths are reminders of a simpler time. And nowhere is the wreath more emblematic than my home State of Maine. Indeed, Maine is the largest producer of balsam fir wreaths in America, owed in large part to the tree's prevalence in our State's landscape. Furthermore, sales of these stunning wreaths contribute millions of dollars to the Maine economy. In recognition of these critical facts, I rise to honor the Whitney Wreath company, a renowned small business headquartered in Washington County.

Whitney Wreath is in its 21st season of producing fragrant and vivid green wreaths for display during the winter holidays. The company was started in 1988 when David Whitney, the company's founder, sold handmade wreaths from the back of a pickup truck during his teenage years. Two decades later, Whitney Wreath is now America's largest mail-order wreath company, selling its products through its own Web site, as well as several other catalogues and outlets including QVC. Incredibly, its wreath sales are now in the hundreds of thousands each year. The company has nine facilities throughout the State, and is in the process of building a tenth to improve productivity. And this year, despite the turbulence in our Nation's economy and an uncertain employment picture, Whitney Wreath was able to hire 250 additional employees over last season because of a substantial new contract.

Decorated with a range of colorful and timely ornaments, such as pine cones, Maine blueberries, sleigh bells, and of course bright red bows, Whitney's wreaths are nothing short of spectacular. Made using fresh Maine balsam fir, the smell of a Whitney wreath is unmistakable, and an outstanding symbol of the season it represents. The company also manufactures a range of Christmas centerpieces and the unique Maine Kissing Ball, consisting of ''snow'' covered pine cones combined with brilliant red berries.

Whitney Wreath has been celebrated over the years for its commitment to quality wreaths. In 2007, the Small Business Administration honored the company with its Jeffrey H. Butland Family-Owned Business of the Year award because of the company's efforts to be involved in the community and provide critical employment opportunities to the citizens of Downeast Maine. The award also paid homage to David Whitney's other small businesses, Whitney's Blueberries and Whitney's Tool Shed.

Finally, in the spirit of the holiday season, it is fitting to acknowledge the magnanimous work Whitney Wreath is doing to support our Nation's breast cancer survivors. Last year, the company asked Facebook users to join the fight against breast cancer and for every 20 people who joined, Mr. Whitney pledged to bring special wreaths with pink ribbons to survivors of the disease. On December 22, 2008, after almost 500 people took his message to heart, David Whitney arrived at Cancer Care of Maine in Brewer with 30 special wreaths.

This year, Mr. Whitney has promised to donate 25 percent of every breast cancer awareness wreath purchased to the Susan G. Komen Breast Cancer Foundation. The company has also announced that it will donate 20 percent of the proceeds from the sales of its Original Christmas Wreaths to the National Autism Association. As we work to combat these terrible illnesses, I am proud to have caring and thoughtful individuals like David Whitney doing their own part to encourage and support those afflicted.

A downeast staple for nearly a quarter of a century, Whitney Wreath has become a leader in its field by combining attention to detail and concern for the community. I thank David Whitney and everyone at Whitney Wreath for all they do to lift our spirits during the holiday season, and wish them many more years of success.•

TRIBUTE TO KENNETH CHRISTOPHER SATTERLEE

• Mr. THUNE. Mr. President, today I recognize Kenneth Christopher Satterlee, an intern in my Washington DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Kenny is a graduate of La Jolla High School in San Diego, CA. Currently he is attending the American University, where he is majoring in history. He is a hard worker who has been dedicated to getting the most out of his internship experience.

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

MESSAGES FROM THE PRESIDENT

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

EXECUTIVE MESSAGES REFERRED

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

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

MESSAGE FROM THE HOUSE

At 11:15 a.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1319. An act to prevent the inadvertent disclosure of information on a computer through certain ''peer-to-peer'' file sharing programs without first providing notice and obtaining consent from an owner or authorized user of the computer.

H.R. 1854. An act to amend the Water Resources Development Act of 1992 to modify an environmental infrastructure project for Big Bear Lake, California.

H.R. 2134. An act to establish the Western Hemisphere Drug Policy Commission.

H.R. 2221. An act to protect consumers by requiring reasonable security policies and procedures to protect data containing personal information, and to provide for nationwide notice in the event of a security breach.

H.R. 2278. An act to direct the President to transmit to Congress a report on anti-American incitement to violence in the Middle East, and for other purposes.

H.R. 2711. An act to amend title 5, United States Code, to provide for the transportation of the dependents, remains, and effects of certain Federal employees who die while performing official duties or as a result of the performance of official duties.

H.R. 3224. An act to authorize the Board of Regents of the Smithsonian Institution to plan, design, and construct a vehicle maintenance building at the vehicle maintenance branch of the Smithsonian Institution located in Suitland, Maryland, and for other purposes.

H.R. 4165. An act to extend through December 31, 2010, the authority of the Secretary of the Army to accept and expend funds contributed by non-Federal public entities to expedite the processing of permits.

H.R. 4217. An act to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to amend title 49, United States Code, to extend authorizations for the airport improvement program, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 199. Concurrent resolution recognizing the 10th Anniversary of the redesignation of Company E, 100th Battalion, 442d Infantry Regiment of the United States Army and the sacrifice of the soldiers of Company E and their families in support of the United States.

H. Con. Res. 206. Concurrent resolution commending the soldiers and civilian personnel stationed at Fort Gordon and their

families for their service and dedication to the United States and recognizing the contributions of Fort Gordon to Operation Iraqi Freedom and Operation Enduring Freedom and its role as a pivotal communications training installation.

H. Con. Res. 213. Concurrent resolution expressing the sense of Congress for and solidarity with the people of El Salvador as they persevere through the aftermath of torrential rains which caused devastating flooding and deadly mudslides.

H. Con. Res. 218. Concurrent resolution expressing sympathy for the 57 civilians who were killed in the southern Philippines on November 23, 2009.

ENROLLED BILL SIGNED

The President pro tempore (Mr. BYRD) reported that he had signed the following enrolled bill, which was previously signed by the Speaker of the House:

S. 1422. An act to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

MEASURES REFERRED

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

H.R. 1319. To prevent the inadvertent disclosure of information on a computer through the use of certain ''peer-to-peer'' file sharing programs without first providing notice and obtaining consent from an owner or authorized user of the computer; to the Committee on Commerce, Science, and Transportation.

H.R. 1854. An act to amend the Water Resources Development Act of 1992 to modify an environmental infrastructure project for Big Bear Lake, California; to the Committee on Energy and Natural Resources.

H.R. 2134. An act to establish the Western Hemisphere Drug Policy Commission; to the Committee on Foreign Relations.

H.R. 2221. An act to protect consumers by requiring reasonable security policies and procedures to protect data containing personal information, and to provide for nationwide notice in the event of a security breach; to the Committee on Commerce, Science, and Transportation.

H.R. 2278. An act to direct the President to transmit to Congress a report on anti-American incitement to violence in the Middle East, and for other purposes; to the Committee on Foreign Relations.

H.R. 2711. An act to amend title 5, United States Code, to provide for the transportation of the dependents, remains, and effects of certain Federal employees who die while performing official duties or as a result of the performance of official duties; to the Committee on Homeland Security and Governmental Affairs.

The following concurrent resolutions were read, and referred as indicated:

H. Con. Res. 196. Concurrent resolution making corrections in the enrollment of the bill H.R. 2647; to the Committee on Armed Services.

H. Con. Res. 199. Concurrent resolution recognizing the 10th Anniversary of the redesignation of Company E, 100th Battalion, 442d Infantry Regiment of the United States Army and the sacrifice of the soldiers of Company E and their families in support of the United States; to the Committee on Armed Services.

H. Con. Res. 206. Concurrent resolution commending the soldiers and civilian personnel stationed at Fort Gordon and their families for their service and dedication to the United States and recognizing the contributions of Fort Gordon to Operation Iraqi Freedom and Operation Enduring Freedom and its role as a pivotal communications training installation; to the Committee on Armed Services.

H. Con. Res. 213. Concurrent resolution expressing the sense of Congress for and solidarity with the people of El Salvador as they persevere through the aftermath of torrential rains which caused devastating flooding and deadly mudslides; to the Committee on Foreign Relations.

H. Con. Res. 218. Concurrent resolution expressing sympathy for the 57 civilians who were killed in the southern Philippines on November 23, 2009; to the Committee on Foreign Relations.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on today, December 9, 2009, she had presented to the President of the United States the following enrolled bill:

S. 1422. An act to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with an amendment:

S. 574. A bill to enhance citizen access to Government information and services by establishing that Government documents issued to the public must be written clearly, and for other purposes (Rept. No. 111–102).

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with an amendment in the nature of a substitute:

S. 1288. A bill to authorize appropriations for grants to the States participating in the Emergency Management Assistance Compact, and for other purposes (Rept. No. 111–103).

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs:

Report to accompany S. 1261, a bill to repeal title II of the REAL ID Act of 2005 and amend title II of the Homeland Security Act of 2002 to better protect the security, confidentiality, and integrity of personally identifiable information collected by States when issuing driver's licenses and identification documents, and for other purposes (Rept. No. 111–104).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. BEGICH (for himself and Ms. SNOWE):

S. 2852. A bill to establish, within the National Oceanic and Atmospheric Administration, an integrated and comprehensive ocean, coastal, Great Lakes, and atmospheric research, prediction, and environmental information program to support renewable energy; to the Committee on Commerce, Science, and Transportation.

By Mr. CONRAD (for himself, Mr. GREGG, Mr. LIEBERMAN, Mr. CHAMBLISS, Mr. NELSON of Florida, Mr. ISAKSON, Mr. BAYH, Mr. VOINOVICH, Mrs. MCCASKILL, Mr. LEMIEUX, Mr. UDALL of Colorado, Mr. ALEXANDER, Mr. BENNET, Mr. CRAPO, Mr. NELSON of Nebraska, Mr. BROWNBACK, Ms. KLOBUCHAR, Mr. CORKER, Mr. WARNER, Mrs. HUTCHISON, Mrs. SHAHEEN, Mr. ENZI, Mr. DORGAN, Mr. BOND, Mr. BENNETT, Mr. ENSIGN, Mr. JOHANNS, Mrs. FEINSTEIN, Mr. MCCAIN, and Mr. CORNYN):

S. 2853. A bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the long-term fiscal stability and economic security of the Federal Government of the United States, and to expand future prosperity growth for all Americans; to the Committee on the Budget .

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

S. 2854. A bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for new qualified hybrid motor vehicles, and for other purposes; to the Committee on Finance.

By Mr. MENENDEZ:

S. 2855. A bill to reallocate a portion of the Troubled Asset Relief Program to increase lending to main street; to the Committee on Banking, Housing, and Urban Affairs.

By Ms. SNOWE (for herself and Mr. KIRK):

S. 2856. A bill to allow the United States-Canada Transboundary Resource Sharing Understanding to be considered an international agreement for the purposes of section 304(e)(4) of the Magnuson-Stevens Fishery Conservation and Management Act; to the Committee on Commerce, Science, and Transportation.

By Mr. BINGAMAN (for himself, Mr. HATCH, Ms. STABENOW, and Mr. LUGAR):

S. 2857. A bill to amend the Internal Revenue Code of 1986 to expand the qualifying advanced energy project credit; to the Committee on Finance .

By Mrs. BOXER (for herself, Mr. DURBIN, Mr. KERRY, and Mr. CASEY):

S. 2858. A bill to amend the Public Health Service Act to establish an Office of Mitochondrial Disease at the National Institutes of Health, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. INOUYE (for himself, Mr. ROCKEFELLER, Ms. SNOWE, Mr. NELSON of Florida, and Mr. KERRY):

S. 2859. A bill to reauthorize the Coral Reef Conservation Act of 2000, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. DODD:

S. 2860. A bill to protect students from inappropriate seclusion and physical restraint, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2861. A bill to amend the Trade Act of 1974 to establish an Assistant United States Trade Representative for Small Business, and for other purposes; to the Committee on Finance.

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2862. A bill to amend the Small Business Act to improve the Office of International Trade, and for other purposes; to the Committee on Small Business and Entrepreneurship.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. CRAPO (for himself and Mr. LIEBERMAN):

S. Res. 373. A resolution designating the month of February 2010 as ''National Teen Dating Violence Awareness and Prevention Month''; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 455

At the request of Mr. ROBERTS, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 455, a bill to require the Secretary of the Treasury to mint coins in recognition of 5 United States Army Five-Star Generals, George Marshall, Douglas MacArthur, Dwight Eisenhower, Henry ''Hap'' Arnold, and Omar Bradley, alumni of the United States Army Command and General Staff College, Fort Leavenworth, Kansas, to coincide with the celebration of the 132nd Anniversary of the founding of the United States Army Command and General Staff College.

S. 534

At the request of Mr. NELSON of Florida, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 534, a bill to amend title XVIII of the Social Security Act to reduce cost-sharing under part D of such title for certain non-institutionalized full-benefit dual eligible individuals.

S. 796

At the request of Mr. BINGAMAN, the name of the Senator from Colorado (Mr. BENNET) was added as a cosponsor of S. 796, a bill to modify the requirements applicable to locatable minerals on public domain land, and for other purposes.

S. 841

At the request of Mr. KERRY, the names of the Senator from Pennsylvania (Mr. CASEY) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 841, a bill to direct the Secretary of Transportation to study and establish a motor vehicle safety standard that provides for a means of alerting blind and other pedestrians of motor vehicle operation.

S. 1147

At the request of Mr. KOHL, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1156

At the request of Mr. HARKIN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1156, a bill to amend the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users to reauthorize and improve the safe routes to school program.

S. 1382

At the request of Mr. DODD, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 1382, a bill to improve and expand the Peace Corps for the 21st century, and for other purposes.

S. 1400

At the request of Ms. STABENOW, the name of the Senator from Virginia (Mr. WEBB) was added as a cosponsor of S. 1400, a bill to amend the Internal Revenue Code of 1986 to make permanent the depreciation classification of motorsports entertainment complexes.

S. 1524

At the request of Mr. KERRY, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 1524, a bill to strengthen the capacity, transparency, and accountability of United States foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.

S. 1932

At the request of Mr. MCCAIN, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from Texas (Mrs. HUTCHISON) were added as cosponsors of S. 1932, a bill to amend the Elementary and Secondary Education Act of 1965 to allow members of the Armed Forces who served on active duty on or after September 11, 2001, to be eligible to participate in the Troops-to-Teachers Program, and for other purposes.

S. 2725

At the request of Mrs. FEINSTEIN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 2725, a bill to provide for fairness for the Federal judiciary.

S. 2794

At the request of Mr. SCHUMER, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 2843

At the request of Ms. STABENOW, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 2843, a bill to provide for a program of research, development, demonstration, and commercial application in vehicle technologies at the Department of Energy.

S. RES. 339

At the request of Mr. SPECTER, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. Res. 339, a resolution to express the sense of the Senate in support of permitting the televising of Supreme Court proceedings.

S. RES. 362

At the request of Mr. SHELBY, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. Res. 362, a resolution expressing the sense of the Senate that the Secretary of the Treasury should direct the United States Executive Directors to the International Monetary Fund and the World Bank to use the voice and vote of the United States to oppose making any loans to the Government of Antigua and Barbuda until that Government cooperates with the United States and compensates the victims of the Stanford Financial Group fraud.

AMENDMENT NO. 2795

At the request of Mr. LEAHY, the name of the Senator from Virginia (Mr. WEBB) was added as a cosponsor of amendment No. 2795 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2798

At the request of Mr. INOUYE, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of amendment No. 2798 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. 2807

At the request of Mr. CORNYN, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of amendment No. 2807 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. 2869

At the request of Mr. NELSON of Florida, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of amendment No. 2869 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. 2903

At the request of Ms. SNOWE, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of amendment No. 2903 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. 2909

At the request of Mr. NELSON of Florida, the names of the Senator from Massachusetts (Mr. KIRK), the Senator from Illinois (Mr. DURBIN) and the Senator from New Jersey (Mr. MENENDEZ) were added as cosponsors of amendment No. 2909 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2924

At the request of Mr. CASEY, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of amendment No. 2924 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2938

At the request of Mrs. GILLIBRAND, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of amendment No. 2938 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2978

At the request of Mr. BEGICH, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from New Mexico (Mr. UDALL) were added as cosponsors of amendment No. 2978 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. 2991

At the request of Mr. MENENDEZ, the names of the Senator from Illinois (Mr. BURRIS) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of amendment No. 2991 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. 2993

At the request of Mr. SCHUMER, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of amendment No. 2993 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. 3004

At the request of Mrs. HAGAN, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of amendment No. 3004 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. 3010

At the request of Ms. LANDRIEU, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of amendment No. 3010 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. 3013

At the request of Ms. LANDRIEU, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of amendment No. 3013 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. 3014

At the request of Ms. LANDRIEU, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of amendment No. 3014 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. 3069

At the request of Mr. KOHL, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of amendment No. 3069 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.

STATEMENTS ON INTRODUCTED BILLS AND JOINT RESOLUTIONS

By Mr. BEGICH (for himself and Ms. SNOWE):

S. 2852. A bill to establish, within the National Oceanic and Atmospheric Administration, an integrated and comprehensive ocean, coastal, Great Lakes, and atmospheric research, prediction, and environmental information program to support renewable energy; to the Committee on Commerce, Science, and Transportation.

Mr. BEGICH. Mr. President, today, I, along with my colleague Senator SNOWE, are introducing legislation to establish a comprehensive ocean, coastal, Great Lakes, and atmospheric research program to support renewable energy. Renewable energy is the most rapidly growing U.S. energy sector. Increasing the use of renewable energy is dependent on baseline atmospheric and oceanic data. Improving NOAA's ability to provide the observations, forecasts, and climate information tailored to the needs of the renewable energy industry will promote growth of this energy sector. This bill would require NOAA to establish a comprehensive research, prediction, and environmental information program to support renewable energy. Specifically, the legislation would require NOAA to develop observation systems and models and collect baseline environmental data to support renewable energy development on land and in the marine environment; and provide best management practices to avoid adverse effects in the marine and coastal environment. The legislation would authorize $100 million annually for fiscal year 2010 through 2014 and allows for up to 50 percent of funds to be available to educational institutions or states to carry out activities in support of the program. As we work as a Nation to decrease our dependency on foreign oil, to encourage scientific advancement, technological innovation and job creation, the Renewable Energy Environmental Research Act of 2009 will be an important component in advancing progress in those areas. I urge my colleagues to support this legislation to support critical research in support of advancing renewable energy development.

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

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

S. 2852

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Renewable Energy Environmental Research Act of 2009''.

SEC. 2. PURPOSE.

The purpose of this Act is to establish an integrated and comprehensive ocean, coastal, Great Lakes, and atmospheric research, prediction, and environmental information program to support renewable energy.

SEC. 3. RENEWABLE ENERGY RESEARCH PLAN.

(a) IN GENERAL.—The Administrator shall develop a plan—

(1) to define requirements for a comprehensive and integrated ocean, coastal, Great Lakes, and atmosphere science program to support renewable energy development in the United States based on the public hearings, public comments, and a review of scientific and industry information;

(2) to identify and describe current climate, weather, and water data programs, products, services, and authorities within NOAA relevant to renewable energy development;

(3) to provide targeted research, data, monitoring, observation, and other information, products, and services concerning climate, weather, and water in support of renewable energy and ''smart grid'' technology, including research to accurately quantify the downstream micro-climate impacts of windpower turbines;

(4) to provide research, data, monitoring, and other information, products, and services to inform renewable energy decisions concerning coastal and marine habitats, living marine resources and the ecosystems on which they depend and coastal and marine planning; and

(5) to reduce duplication and leverage the resources of existing NOAA programs through coordination with—

(A) other offices and programs within NOAA, including the atmospheric, ocean, and coastal observation systems;

(B) Federal, State, tribal, and local observation systems; and

(C) other entities, including the private sector organizations and institutions of higher education; and

(6) to facilitate public-private cooperation, including identification and assessment of current private sector capabilities.

(b) PUBLIC HEARINGS.—In developing the plan, the Administrator shall provide public notice and opportunity for 1 or more public hearings and shall seek comments from Federal and State agencies, tribes, local governments, representatives of the private sector, and other parties interested in renewable energy observations, data, and use in order to improve NOAA climate, weather, and water observation data products and services to more effectively support renewable energy development.

SEC. 4. ESTABLISHMENT OF RESEARCH, PREDICTION, AND ENVIRONMENTAL INFORMATION PROGRAM.

(a) IN GENERAL.—Within 18 months after the date of enactment of this Act, the Administrator shall establish a program to develop and implement an integrated and comprehensive ocean, coastal, Great Lakes and atmosphere research and operations program, based on the plan required by section 3, to support renewable energy development in the United States.

(b) PROGRAM COMPONENTS.—At a minimum, the program shall include—

(1) improvements in coordinated climate, weather, and water research, monitoring, and observations to support—

(A) renewable energy development; and

(B) the understanding and mitigation of the impact of renewable energy development on living marine resources, including protected species and the marine and coastal environment;

(2) coordinated weather, water, and climate prediction capability focused on renewable energy and ''smart grid'' technology to provide information and decision services in support of renewable energy development;

(3) support for the transition to, and reliable delivery of, sustained operational weather, water, and climate products from research, observation, and prediction outputs;

(4) means of identifying biological and ecological effects of marine renewable energy development on living marine resources, the marine and coastal environment, marine-dependent industries, and coastal communities;

(5) baseline ecological characterization, including research, data collection, and mapping, of the coastal and marine environment and living marine resources for marine renewable energy development;

(6) avoidance, minimization, and mitigation strategies to address the potential impacts of marine renewable energy on the marine, coastal, and Great Lakes environment, including developing effective monitoring protocols, use of adaptive management, informed engineering design and operating parameters, and the establishment of protocols for minimizing the environmental impacts of testing, developing, and deploying marine renewable energy devices;

(7) support for the development of marine special area management plan by states as defined by the Coastal Zone Management Act of 1972 (16 U.S.C. 1451 et seq.) that would support renewable energy development consistent with natural resource protection and other coastal-dependent economic growth;

(8) comprehensive digital mapping, modeling, and other geospatial information and services to support planning for renewable energy and stewardship of ecosystem and living marine ecosystems, including protected species, in ocean and coastal areas;

(9) a coordinated approach for examining and quantifying the micro-climate impacts of wind-power farms on soil transpiration and drying; and

(10) provision for outreach to the public and private sector about program research, information, and products, including making non-proprietary information and best management practices developed under this program available to the public.

(c) USE IN AGENCY DECISIONS.—The program established under subsection (b) shall be designed to collect, synthesize, and distribute data in a manner that can be used by marine resource managers responsible for making decisions about marine renewable energy projects. The Army Corps of Engineers, Department of Commerce, Minerals Management Service, Federal Energy Regulatory Commission, and Department of Energy shall consider this information when making planning, siting, and permitting decisions for marine renewable energy.

(d) SUPPORT FOR PUBLIC-PRIVATE COOPERATION.—To the extent practicable, in implementing the program established under this section, the Administrator shall seek appropriate opportunities to facilitate and expand cooperation with private sector entities to develop and expand information services that serve the renewable energy industry.

SEC. 5. BIENNIAL REPORTS.

Not later than 2 years after the date of the enactment of this Act and every 2 years thereafter, the Administrator shall prepare and transmit a report to the Senate Committee on Commerce, Science, and Transportation, the House of Representatives Committee on Natural Resources, and the House of Representatives Committee on Science and Technology on progress made in implementing this Act, including—

(1) a description of activities carried out under this Act;

(2) recommendations for priority activities under this Act for fiscal years beginning after the date on which the report is submitted; and

(3) funding levels for activities under this Act in those fiscal years

SEC. 6. LIBRARY.

Within 1 year after the date of the enactment of this Act, the Administrator, in consultation with relevant Federal agencies, shall establish a renewable energy information library and data portal. The library shall include, at a minimum—

(1) links to data and information products for use in renewable energy development;

(2) links to planning and decision support tools for use in renewable energy development;

(3) data about the baseline condition of ocean and coastal resources; and

(4) links to digital mapping and geospatial information, products, and services described in section 4(b).

SEC. 7. FEDERAL COORDINATION.

In carrying out activities under this Act, the Administrator shall coordinate with the Secretary of the Interior, the Secretary of Energy, the Secretary of Transportation, the Secretary of Defense, the Federal Energy Regulatory Commission, the Department in which the Coast Guard is operating, and the heads of other relevant Federal agencies.

SEC. 8. AGREEMENTS.

The Administrator may enter into and perform such contracts, leases, grants, cooperative agreements, or other agreements and transactions with any agency or instrumentality of the United States, or with any State, local, tribal, territorial or foreign government, or with any person, corporation, firm, partnership, educational institution, nonprofit organization, or international organization as may be necessary to carry out the purposes of this Act.

SEC. 9. AUTHORITY TO RECEIVE FUNDS.

The Administrator may accept, retain, and use funds received from any party pursuant to an agreement entered into under section 8 for activities furthering the purposes of this Act.

SEC. 10. USE OF OCEAN OBSERVING OFFSHORE INFRASTRUCTURE.

(a) IN GENERAL.—Any offshore exploration and production facility, at the discretion of the Administrator, may execute a memorandum of understanding authorizing the use of offshore platforms and infrastructure for the placement of meteorological and oceanographic observation sensors of a type to be designated by the Administrator in support of the Integrated Ocean Observing System.

(b) AVAILABILITY OF INFORMATION.—All information collected by such sensors will be managed by NOAA and be readily available for use in spill response as well as available to the National Weather Service, other NOAA programs, and the general public.

SEC. 11. DEFINITIONS.

In this Act:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Under Secretary of Commerce for Oceans and Atmosphere in the Under Secretary's capacity as Administrator of NOAA.

(2) MARINE RENEWABLE ENERGY.—The term ''marine renewable energy'' means any form of renewable energy derived from the sea including wave energy, tidal energy, ocean current energy, offshore wind energy, salinity gradient energy, ocean thermal gradient energy, and ocean thermal energy conversion.

(3) NOAA.—The term ''NOAA'' means the National Oceanic and Atmospheric Administration.

SEC. 12. AUTHORIZATION OF APPROPRIATIONS.

(a) IMPLEMENTATION AND EXECUTION.—There are authorized to be appropriated to the Administrator $100,000,000 for each of fiscal years 2010 through 2014 to carry out this Act.

(b) GRANTS TO EDUCATIONAL INSTITUTIONS AND COASTAL STATES.—Of the amounts appropriated pursuant to subsection (b), the Administrator shall make up to 50 percent available to educational institutions, and to States with coastal zone management programs approved under the Coastal Zone Management Act of 1972 (16 U.S.C. 1451 et seq.), to carry out activities that support the program established under section 4.

SEC. 13. SAVINGS PROVISION.

Nothing in this Act shall be construed to supersede or modify the jurisdiction, responsibilities, or authority of any Federal or State agency under any provision of law in effect on the date of enactment of this Act.

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

S 2854. A bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for new qualified hybrid motor vehicles, and for other purposes; to the Committee on Finance.

Mr. KOHL. Mr. President, I rise today to introduce a bill with Senator HATCH that would provide tax credits for purchasers of hybrid and plug-in hybrid heavy duty trucks. Specifically, this bill would extend the existing heavy duty hybrid tax credit and create a tax credit for heavy duty plug-in hybrid trucks. The plug-in tax credit was included in the Senate passed stimulus bill, but was dropped in conference. Both tax credits would begin at $15,000 for those vehicles weighing up to 14,000 lbs and max out at $100,000

for vehicles weighing more than 33,000 lbs. The tax credits would expire in 2014.

The challenge for hybrid and plug-in hybrid technologies is cost. Advanced batteries and components are new and expensive technologies. In the medium and heavy duty sector, these costs are even higher and vehicle turnover is lower. The incremental cost of a heavy duty plug-in hybrid over 23,000 lbs can be as much as $85,000. We are introducing this bill to provide the needed incentives for manufacturers to develop and install hybrid and plug-in hybrid technology on heavy duty trucks.

This bill also includes a tax credit of up to $3,500 for trucks stops to install electrification units so that truckers could plug in their vehicles to operate necessary systems without idling the engine. Because the Department of Transportation mandates that truckers rest for 10 hours after driving for 11 hours, truckers idle at truck stops for several hours. With this tax credit, truckers would be able to operate the heater, air conditioner, television, and other appliances without running the engine, which saves fuel, reduces air pollution, and reduces engine wear. The tax credit would end in 2014.

In addition to reducing oil use in their drive cycles, electrification is an important technology for reducing idle costs and emissions. U.S. trucks idle an average of 1830 hours per year. The idling of commercial vehicles is estimated to consume more than 2 billion gallons of fuel annually, while producing unwanted emissions. By promoting onboard electricity options for powering vehicle functions while idling and by expanding off board options, through truck stop electrification, this legislation will reduce oil use and emissions from this sector even further.

This bill, which has the support of the Electric Drive Transportation Association, will help manufacturers reach the economies of scale by bringing down the costs of hybrid and plug-in hybrid technologies. The tax credits will promote the purchases of clean, efficient electric drive trucks and the installation of anti-idling equipment that will improve our environment and reduce our dependence on foreign oil.

By Mr. BINGAMAN (for himself Mr. HATCH, Ms. STABENOW, and Mr. LUGAR):

S. 2857. A bill to amend the Internal Revenue Code of 1986 to expand the qualifying advanced energy project credit; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, a recent report by the New America Foundation finds that ''the United States ran an overall green trade deficit of −$8.9 billion in 2008, including a deficit of −$6.4 billion in the critical category of renewable energy. . .'' To halt this trend and promote American leadership in clean technology manufacturing, I was pleased to see the Advanced Energy Manufacturing Tax Credit, codified as Section 48C of the Internal Revenue Code, established under the American Recovery and Reinvestment Act. Under Section 48C, qualifying projects receive a 30 percent tax credit for capital expenditures related to new, expanded, or re-equipped advanced energy manufacturing projects. But Section 48C was enacted subject to a $2.3 billion limitation in allocation authority—and we expect the full $2.3 billion soon to be exhausted. Because we cannot allow this credit to lapse, I rise today to introduce the American Clean Technology Manufacturing Leadership Act, which would add $2.5 billion in allocation authority to the Section 48C Advanced Energy Manufacturing Tax Credit program. I am pleased to be joined by Senator HATCH, Senator STABENOW, and Senator LUGAR in introducing this bill.

By establishing the Section 48C credit, Congress took a significant step—but we cannot slow down now. In the near- to mid-term, we can anticipate rapid growth in demand for renewable energy technologies, due to the long-term extension of the production tax credit and the commercial and residential investment tax credits; declining product costs; the anticipated enactment this Congress of a national renewable portfolio standard; and the anticipated implementation of a carbon control system. But without robust incentives, foreign-based manufacturers are poised to seize a large share of this domestic growth in the clean power market with products exported to the United States. As New America explains: ''If current trends continue, the green trade deficit can be expected to widen further as the administration's agenda increases domestic demand but without sufficient measures to increase domestic production. If the deficit continues to grow, the United States will forego the creation of millions of high-wage, high-skill green manufacturing jobs and lose its potential to be a global producer as well as a consumer of green technologies.''

The reality is that we need a level playing field to bring manufacturing jobs to the United States. For years, Germany, China, India, Malaysia, and the Philippines have offered incentives that have placed the United States at a competitive disadvantage. For instance, for solar photovoltaic manufacturers, Malaysia and the Philippines offer income tax holidays, 15 years in the case of Malaysia, and Germany offers up to 30 percent of investment costs for large enterprises and 40–50 percent for smaller enterprises.

The Section 48C Advanced Energy Manufacturing Tax Credit made an important stride in leveling that playing field. ARRA instructed Treasury and DOE to establish a selection procedure for allocating credits, thus ensuring that only the most promising projects receive a Federal investment. But the program is oversubscribed and we anticipate that by January 15, the full $2.3 billion authorized under ARRA will be allocated.

We cannot afford to have this credit lapse. There are additional qualified applications ready to be evaluated, and an existing selection infrastructure to make these awards quickly. To keep us on track, our bill would add an additional $2.5 billion in allocation authority—enough to leverage an additional $8.3 billion in investment in domestic manufacturing facilities.

Yesterday President Obama himself called for an expansion of this credit. Speaking at the Brookings Institution, the President said that the Treasury program has received a substantial response and warrants an expansion: ''It's a positive sign that many of these programs drew so many applicants for funding that a lot of strong proposals—proposals that will leverage private capital and create jobs quickly—did not make the cut,'' President Obama said. ''With additional resources, in areas like advanced manufacturing of wind turbines and solar panels, for instance, we can help turn good ideas into good private-sector jobs.''

We should move immediately to meet the President's call, by adding $2.5 billion in allocation authority. Allowing this credit to lapse would only cede high-paying jobs to other countries at a time when our unemployment rate hovers above 10 percent.

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

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

S. 2857

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''American Clean Technology Manufacturing Leadership Act''.

SEC. 2. EXPANSION OF QUALIFYING ADVANCED ENERGY PROJECT CREDIT.

(a) IN GENERAL.—Section 48C(d)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ''$2,300,000,000'' and inserting ''$4,800,000,000''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to allocations for applications submitted after December 31, 2009.

By Mrs. BOXER (for himself, Mr. DURBIN, Mr. KERRY, and Mr. CASEY):

S. 2858. A bill to amend the Public Health Service Act to establish an Office of Mitochondrial Disease at the National Institutes of Health, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. BOXER. Mr. President, as we work to reform our health care system, it is crucial that we encourage the development of new treatments and cures for diseases by investing in health research and innovation. Today, I am proud to introduce the Brittany Wilkinson Mitochondrial Disease Research and Treatment Enhancement Act of 2009, which, for the first time,

would coordinate the federal investment in researching the cause of, and treatments and cures for, mitochondrial disease.

Known as the cell's ''powerhouse,'' mitochondria are specialized compartments within cells that help sustain life by producing 90 percent of the energy our cells and bodies need. Mitochondrial disease causes defects that reduce the ability of mitochondria to produce energy, which leads to cell dysfunction or death. When cells in our bodies begin to fail or die, then whole organ systems can fail.

Due to the essential nature of the function of mitochondria, mitochondrial dysfunction is suspected to be associated with a large number of diseases including, Parkinson's, autism, diabetes, cancer and many other afflictions. However, we cannot learn more about how these diseases are related until we invest enough resources in mitochondrial disease research.

First recognized in the 1960s, mitochondrial disease is relatively newly diagnosed, yet every 30 minutes a child is born who will develop a mitochondrial disease by age 10, and one recent study showed that one in every 200 people has a genetic mutation that may lead to mitochondrial disease.

Despite its prevalence, mitochondrial disease has no known treatment or cure, those afflicted with this disorder—many of them children—go untreated.

This legislation would create an Office of Mitochondrial Disease, within the National Institutes of Health, to develop a Mitochondrial Disease Research Plan, to promote and coordinate efforts to educate researchers and health providers about mitochondrial diseases and to award grants to increase research of mitochondrial disease.

In addition, this legislation would establish Mitochondrial Disease Centers of Excellence to promote basic and clinical research, facilitate training programs in mitochondrial disease, and develop and disseminate programs to provide continuing education in mitochondrial disease. This legislation also instructs the Director of the CDC to establish a national registry and a biorepository to help collect and share information about patients with mitochondrial disease.

The United Mitochondrial Disease Foundation, UMDF—the voice for the thousands of children, adults and their families who face this disease almost alone—greatly supports this bill because they know it is critical to research, understanding and future treatments for mitochondrial diseases.

Brittany Wilkinson, for whom this act is named, was herself a mitochondrial disease patient. Earlier this year I met this young woman when she visited my office as a UMDF Youth Ambassador; I was greatly impressed by her poise and dedication to her cause. Although Brittany had experienced medical problems since birth, she was not diagnosed with mitochondrial disease until the age of seven.

Though Brittany was in constant pain, spent months in the hospital and sometimes stopped breathing at night, she devoted her life to raising awareness about the disease she shared with so many others. As the first ever Youth Ambassador for the UMDF, Brittany helped fundraise, made phone calls and dictated letters—sometimes from her hospital bed.

In addition to her work as a Youth Ambassador, Brittany was also active in her local government, where she worked to pass ''Mitochondrial Disease Awareness Week'' resolutions in Clovis City and Frenso, California. On the state level, this year she was able to get a permanent resolution through the California Assembly to make the third full week in September every year ''Mitochondrial Disease Awareness Week''. I was devastated to hear that this September Brittany passed due to the effects of her debilitating illness.

Brittany Wilkinson worked tirelessly to advance public awareness of this devastating disease, now I urge my colleagues to join me in taking the next step by supporting this investment in mitochondrial disease research, for the thousands of families across our nation coping with mitochondrial disease.

By Mr. INOUYE (for himself, Mr. ROCKEFELLER, Ms. SNOWE, Mr. NELSON of Florida, and Mr. KERRY):

S. 2859. A bill to reauthorize the Coral Reef Conservation Act of 2000, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. INOUYE. Mr. President, I am pleased to sponsor the Coral Reef Conservation Amendments Act of 2009. This bill reauthorizes and strengthens the Coral Reef Conservation Act of 2000, a program that I originally sponsored in the 106th Congress establishing the Coral Reef Conservation Program at the National Oceanic and Atmospheric Administration, NOAA.

Coral reefs are among the oldest and most economically and biologically important ecosystems in the world. They provide habitat for more than one million diverse aquatic species, a natural barrier for protection from coastal storms and erosion, and are a potential source of treatment for many of the world's diseases. In addition, reef-supported tourism is a $30 billion industry worldwide, and the commercial value of U.S. fisheries from coral reefs is more than $100 million. However, our coral reef ecosystems face many threats including pollution, climate change and coral bleaching, and overfishing to name a few. Coral reefs cover only one-tenth of one percent of the ocean floor, yet provide habitat for more than 25 percent of all marine species.

The original Coral Reef Conservation Act of 2000 recognized the need to preserve, sustain and restore the condition of these valuable coral reef ecosystems. It directed NOAA to develop a National Coral Reef Action Strategy, established a NOAA Coral Reef Conservation Program, and created a Coral Reef Conservation Fund to support public-private partnership projects. The Coral Reef Conservation Act of 2000 also authorized NOAA to provide emergency grants to address unforeseen and disaster-related impacts to coral reefs.

The Coral Reef Conservation Amendments Act of 2009 would strengthen NOAA's ability to comprehensively address threats to coral reefs and empower the agency with tools to ensure that damage to our coral reef ecosystems is prevented or effectively mitigated. It also establishes consistent practices for maintaining data, products, and information, and promotes the widespread availability and dissemination of that environmental information.

The bill allows the Secretary to further develop partnerships with foreign governments and international organizations as well as with Federal agencies, State and local governments, tribal organizations, educational institutions, nonprofit organizations, commercial organizations, and other public and private entities. These partnerships are critical not only to the understanding of our coral reef ecosystems, but also to their protection and restoration. Finally, the bill allows for any amount received by the United States as a result of illegal activity resulting in the destruction, take, loss, or injury of coral reefs to be used toward restoration efforts.

I would urge my colleagues to support this important legislation and I hope that we may pass this bill quickly to continue supporting NOAA's leadership role in coral reef conservation.

By Mr. DODD:

S. 2860. A bill to protect students from inappropriate seclusion and physical restraint, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. DODD. Mr. President, in 1998, the Hartford Courant ran an award-winning series of stories about the use of restraint and seclusion in hospitals, residential facilities, and group homes for individuals with psychiatric and developmental disabilities.

The Courant uncovered a hidden epidemic, confirming 142 deaths occurring during or after the use of restraint or seclusion.

One of those 142 was an 11-year-old boy from my home State of Connecticut. He was restrained face-down in a position that restricted his air flow. He died as a result.

In response, I led the charge to establish Federal standards to prevent the misuse of these practices. I helped pass The Children's Health Act of 2000, which included the Compassionate Care

Act that I originally drafted to put these standards in place in certain hospitals and residential facilities. We wanted to include schools in this legislation, but were unable to do so. Sadly, the need could not have been greater.

Over the past year, reports from the National Disability Rights Network, NDRN, the Alliance to Prevent Restraint, Aversive Interventions, and Seclusion, APRAIS, the Council of Parent Attorneys and Advocates, Inc., COPAA, and the Government Accountability Office, GAO, have painted a picture disturbingly similar to the one the Hartford Courant discovered more than a decade ago.

The statistics are chilling—hundreds of incidents of physical injury, psychological trauma, even death—but the stories are devastating.

Here are some of the examples the GAO found in their report released on May 19, 2009.

A 14-year-old boy was restrained face-down by a teacher because he would not stay seated in class. The 230 lb. teacher sat on the 129 lb. boy, restricting his airflow and resulting in the boy's death.

A 4-year-old girl with cerebral palsy and autism was restrained in a wooden chair with leather straps for being ''uncooperative.''

In one school district, children with disabilities as young as 6 years old were allegedly placed in strangleholds, restrained for extended periods of time, confined to dark rooms, tethered to ropes, and prevented from using the restroom until they urinated on themselves.

To be clear, school personnel mean no harm, and my concern signifies no disrespect for the difficult job they do or the dangers they sometimes face.

But these tragic stories reflect inadequate training, and a lack of resources on the local level to implement effective interventions, such as school-wide positive behavioral supports.

Just as students have a right to learn in a safe environment, educators have a right to work in a safe environment. They should be provided with training and support to prevent injury to themselves and others.

In some States, like Connecticut, parents have successfully advocated for laws that provide these resources, as well as guidelines to ensure that they are used effectively.

But the patchwork of State laws and regulations is confusing.

According to the GAO study, 19 States have no law or regulations concerning restraint and seclusion in schools.

Some laws apply to only certain schools or situations.

Some apply to restraint but not seclusion.

Only 19 States require parental notification.

Only 17 States require staff training.

Only 8 specifically prohibit restraints that restrict air flow.

Furthermore, this patchwork is obviously inadequate; according to a report by COPPA, over 71 percent of the 185 incidents they identified occurred in schools with no positive behavioral interventions or supports.

Therefore, I rise today to introduce the Preventing Harmful Restraint and Seclusion in Schools Act, a bill that will address this void.

It will establish clear minimum standards for the use of restraint and seclusion in schools, closely based on the Children's Health Act of 2000. It will also provide resources to assist with policy implementation and provide school personnel with necessary tools, training, and support.

Finally, it will improve data collection, analysis, and identification of effective practices to prevent and reduce restraint and seclusion in schools, so we may better understand the scope of the problem and the effectiveness of our solutions.

Specifically, the legislation will prohibit the use of restraint and seclusion in schools unless the student's behavior imposes an immediate danger of physical injury and less restrictive interventions would be ineffective.

It will prohibit the use of mechanical, chemical, and physical restraints that restrict air flow to the lungs.

It will require adequate training and state certification of school personnel imposing restraint or seclusion, immediate parental notification when such an incident occurs, and debriefing to prevent future incidents.

As a condition of receiving federal education funding, states will be required to submit annual plans to the Secretary of Education which describe their restraint and seclusion policies, and certify that minimum standards are being met.

States will also be required to report annually the total number of incidents of restraint and seclusion, disaggregated by demographic and other categories.

In order to assist States, local educational agencies, and schools with implementing policies and procedures to meet the minimum standards, competitive grants will be provided. Grants will also assist with the implementation of school-wide positive behavioral supports to further prevent incidents of restraint and seclusion.

Finally, the Department of Education will conduct, and provide to Congress, a national assessment which analyzes data on restraint and seclusion and effective practices in preventing and reducing incidents. This will provide us with a more accurate picture of the extent of restraint and seclusion in schools and help direct additional future efforts to ensure that our children and those who educate them are safe.

I want to thank the many organizations representing individuals with disabilities, students, teachers, and schools that all came to the table with recommendations. I am also grateful to Secretary Duncan for his leadership on this issue. Finally, I want to thank my colleague and good friend Chairman GEORGE MILLER in the House of Representatives. Today, he's introducing companion legislation, and I look forward to working with him to make it law.

Every child has a right to be safe in the place where they go to learn and grow. Every educator deserves the training and support they need to do their jobs safely and effectively. This legislation will help to prevent tragedies in our schools. I am proud to introduce it today, and I urge my colleagues to join me.

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2861. A bill to amend the Trade Act of 1974 to establish an Assistant United States Trade Representative for Small Business, and for other purposes; to the Committee on Finance.

Ms. SNOWE. Mr. President, I rise today with my colleague, Senate Small Business Committee Chair LANDRIEU, to introduce the Small Business Trade Representation Act of 2009. This bipartisan measure would once and for all establish an Assistant United States Trade Representative for Small Business, to ensure that small businesses are represented in trade negotiations and in U.S. trade policy.

I first introduced legislation in 2001, in the 107th Congress, to establish a United States Trade Representative for Small Business, in order to ensure that small business interests are reflected in U.S. trade policy and trade agreement negotiations. Since that time, we've heard excuse after excuse, from Administrations of both parties, about why we don't need an Assistant USTR for Small Business. Currently, less than one percent of all small businesses are exporting their goods and services to foreign customers. Until we see significant gains in small business participation in international trade, we must make it a priority across the Federal government—and especially in our trade policy—to help small businesses compete in the global marketplace.

As Ranking Member of the Senate Committee on Small Business and Entrepreneurship, and as a senior member of both the Senate Finance and Commerce Committees, one of my top priorities is to ensure that small businesses get the promised benefits of our international trade relationships and are able to compete in the world economy.

While globalization has created opportunities for U.S. small businesses to sell their goods and services in new markets, not enough small businesses are taking advantage of these international prospects. In fact, according to the U.S. Department of Commerce, less than one percent of the approximately 27 million U.S. small businesses currently sell their products to foreign buyers. Small businesses are a vital source of economic growth and job creation, generating nearly ⅔ of net new jobs each year. Small businesses are essential to our economic recovery, and

we must help them take advantage of all potential opportunities, including those in foreign markets.

Small businesses can survive, diversify, and compete effectively in the international marketplace by developing an export business. But, as I mentioned, too few small businesses are expanding into international markets. This legislation will help ensure that small businesses are a priority in the U.S. government's trade policy and in future trade agreements.

We cannot overlook the impact of trade on small businesses. An investment in small business exporting assistance is an investment in our economy. I ask all of my Senate colleagues to support this vital legislation.

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

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

S. 2861

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Trade Representation Act of 2009''.

SEC. 2. ASSISTANT UNITED STATES TRADE REPRESENTATIVE FOR SMALL BUSINESS.

(a) ESTABLISHMENT OF POSITION.—Section 141(c) of the Trade Act of 1974 (19 U.S.C. 2171(c)) is amended by adding at the end the following new paragraph:

''(6)(A) There is established within the Office the position of Assistant United States Trade Representative for Small Business, who shall be appointed by the United States Trade Representative.

''(B) The Assistant United States Trade Representative for Small Business shall—

''(i) promote the trade interests of small-business concerns (as that term is defined in section 103 of the Small Business Investment Act of 1958 (15 U.S.C. 662));

''(ii) advocate for the reduction of foreign trade barriers with respect to the trade issues of small-business concerns that are exporters;

''(iii) collaborate with the Administrator of the Small Business Administration with respect to the trade issues of small-business concerns;

''(iv) assist the United States Trade Representative in developing trade policies that increase opportunities for small-business concerns in foreign and domestic markets, including polices that reduce trade barriers for small-business concerns; and

''(v) perform such other duties as the United States Trade Representative may direct.

''(C) The Assistant United States Trade Representative for Small Business shall be compensated at the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code.''.

(b) CONFORMING REPEAL.—Section 2112 of the Bipartisan Trade Promotion Authority Act of 2002 (19 U.S.C. 3812) is repealed.

(c) TECHNICAL CORRECTIONS.—Section 141 of the Trade Act of 1974 (19 U.S.C. 2171), as amended by subsection (a), is further amended—

(1) in subsection (c), by moving paragraph (5) 2 ems to the left; and

(2) in subsection (e)—

(A) in paragraph (1), by striking ''5314'' and inserting ''5315''; and

(B) in paragraph (2), by striking ''the maximum rate of pay for grade GS–18 as provided in section 5332'' and inserting ''the maximum rate of pay for level IV of the Executive Schedule in section 5315''.

Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2862. A bill to amend the Small Business Act to improve the Office of International Trade, and for other purposes; to the Committee on Small Business and Entrepreneurship.

Ms. SNOWE. Mr. President, I rise today with my colleague, Senate Small Business Committee Chair LANDRIEU, to introduce the Small Business Export Enhancement and International Trade Act of 2009. This bipartisan measure would provide improved and expanded support for small businesses, through critical programs and reforms, to ensure that, as we emerge from this protracted recession, American small businesses are primed for success in the global marketplace and are able to create and sustain high-paying jobs.

I would like to thank Chair LANDRIEU for her efforts on this critical issue and for working with me and my staff to merge our respective bills into one bipartisan measure that will help small businesses stay competitive, help them grow, and speed the recovery of our economy as a whole.

As Ranking Member of the Senate Committee on Small Business and Entrepreneurship, and as a senior member of both the Senate Finance and Commerce Committees, one of my top priorities is to ensure that small businesses get the promised benefits of our international trade relationships and are able to compete in the world economy.

While globalization has created opportunities for U.S. small businesses to sell their goods and services in new markets, not enough small businesses are taking advantage of these international prospects. In fact, according to the U.S. Department of Commerce, less than one percent of the approximately 27 million U.S. small businesses currently sell their products to foreign buyers. Small businesses are a vital source of economic growth and job creation, generating nearly ⅔ of net new jobs each year. Small businesses are essential to our economic recovery, and we must help them take advantage of all potential opportunities, including those in foreign markets.

Small businesses face particular challenges in exporting. It can be difficult for small exporting firms to secure the working capital needed to fulfill foreign purchase orders, for instance, because many lenders won't lend against export orders or export receivables. Small business owners may not know how to connect with foreign buyers, or may not have the time or resources necessary to understand other countries' rules and regulations.

Currently, Federal programs are grossly inadequate at helping small businesses overcome the challenges of exporting. The Small Business Export Enhancement and International Trade Act, which we are introducing today, gives small businesses the critical resources and assistance needed to explore potential export opportunities, or to expand their current export business.

Our bipartisan legislation includes provisions from bills I have introduced in past Congresses, since the 109th, to elevate the head of the Small Business Administration, SBA, office responsible for trade and export programs to the Associate Administrator-level, reporting directly to the administrator.

Further, it includes all of the key provisions from the small business trade bill that I introduced earlier this year, S. 1208, the Small Business Export Opportunity Development Act of 2009. These critical provisions would bolster the SBA's technical assistance programs and improve export financing programs to ensure that small businesses have access to the capital needed to support export sales. The legislation also increases the coordination among other federal agencies—the Department of Commerce, the Office of the U.S. Trade Representative, and the Export-Import Bank—to ensure that small businesses benefit from all the export assistance the Federal Government offers.

This legislation also includes a program I proposed earlier this year in S. 1208 to provide grants to help small businesses start or expand export activity, such as participation in foreign trade missions, foreign market sales trips, training workshops and payment of website translation fees. It also improves the SBA's network of international trade counselors and enhances the export assistance provided to small business clients through the Small Business Development Center network, which has over 1,000 locations nationwide.

Our bill increases the maximum size of SBA-guaranteed export working capital and international trade loans from a current level of $2 million to a new level of $5 million, consistent with the levels established in my bill, S. 1615, the Next Steps for a Main Street Recovery Act, which I introduced in August and the President called for last month. This bill also establishes a permanent Export Express program, a streamlined, expedited loan program to get capital to exporters quickly and efficiently, so they can focus on the terms of the sale and preparing their product for shipment. It also establishes a program to provide support for small businesses related to trade disputes and unfair international trade practices, which is critical for our entrepreneurs who have suffered from illegal activities by our trading partners.

Small businesses can survive, diversify, and compete effectively in the international marketplace by developing an export business. But, as I mentioned, too few small businesses are expanding into international markets. This legislation will help small

business owners take the crucial steps of finding international buyers for their goods and services and will enable small business owners to secure the financing needed to fill orders from foreign buyers.

This investment could yield tremendous returns for our economy. The United States spends just one-sixth of the international average on export promotion and assistance among developed countries in promoting small businesses exports. Every additional dollar spent on export promotion results in a 40-fold increase in exports, according to a World Bank study.

We cannot overlook the impact of trade on small businesses. An investment in small business exporting assistance is an investment in our economy. I ask all of my Senate colleagues to support this vital legislation.

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

S. 2862

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Export Enhancement and International Trade Act of 2009''.

SEC. 2. DEFINITIONS.

(a) DEFINITIONS.—In this Act—

(1) the terms ''Administration'' and ''Administrator'' mean the Small Business Administration and the Administrator thereof, respectively;

(2) the term ''Associate Administrator'' means the Associate Administrator for International Trade appointed under section 22(a)(2) of the Small Business Act, as amended by this Act;

(3) the term ''Export Assistance Center'' means a one-stop shop referred to in section 2301(b)(8) of the Omnibus Trade and Competitiveness Act of 1988 (15 U.S.C. 4721(b)(8));

(4) the term ''rural small business concern'' means a small business concern located in a rural area, as that term is defined in section 1393(a)(2) of the Internal Revenue Code of 1986; and

(5) the term ''small business concern'' has the meaning given that term under section 3 of the Small Business Act (15 U.S.C. 632).

(b) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) DEFINITIONS.—Section 3 of the Small Business Act (15 U.S.C. 632) is amended by adding at the end the following:

''(t) SMALL BUSINESS DEVELOPMENT CENTER.—In this Act, the term 'small business development center' means a small business development center described in section 21.

''(u) REGION OF THE ADMINISTRATION.—In this Act, the term 'region of the Administration' means the geographic area served by a regional office of the Administration established under section 4(a).''.

(2) CONFORMING AMENDMENT.—Section 4(b)(3)(B)(x) of the Small Business Act (15 U.S.C. 633(b)(3)(B)(x)) is amended by striking ''Administration district and region'' and inserting ''district and region of the Administration''.

SEC. 3. OFFICE OF INTERNATIONAL TRADE.

(a) ESTABLISHMENT.—Section 22 of the Small Business Act (15 U.S.C. 649) is amended—

(1) by striking ''SEC. 22. (a) There'' and inserting the following:

''SEC. 22. OFFICE OF INTERNATIONAL TRADE.

''(a) ESTABLISHMENT.—

''(1) OFFICE.—There''; and

(2) in subsection (a)—

(A) in paragraph (1), as so designated, by striking the period and inserting ''for the primary purposes of increasing—

''(A) the number of small business concerns that export; and

''(B) the volume of exports by small business concerns.''; and

(B) by adding at the end the following:

''(2) ASSOCIATE ADMINISTRATOR.—The head of the Office shall be the Associate Administrator for International Trade, who shall be responsible to the Administrator.''.

(b) AUTHORITY FOR ADDITIONAL ASSOCIATE ADMINISTRATOR.—Section 4(b)(1) of the Small Business Act (15 U.S.C. 633(b)(1)) is amended—

(1) in the fifth sentence, by striking ''five Associate Administrators'' and inserting ''Associate Administrators''; and

(2) by adding at the end the following: ''One such Associate Administrator shall be the Associate Administrator for International Trade, who shall be the head of the Office of International Trade established under section 22.''.

(c) DISCHARGE OF INTERNATIONAL TRADE RESPONSIBILITIES OF ADMINISTRATION.—Section 22 of the Small Business Act (15 U.S.C. 649) is amended by adding at the end the following:

''(h) DISCHARGE OF INTERNATIONAL TRADE RESPONSIBILITIES OF ADMINISTRATION.—The Administrator shall ensure that—

''(1) the responsibilities of the Administration regarding international trade are carried out by the Associate Administrator;

''(2) the Associate Administrator has sufficient resources to carry out such responsibilities; and

''(3) the Associate Administrator has direct supervision and control over—

''(A) the staff of the Office; and

''(B) any employee of the Administration whose principal duty station is an Export Assistance Center, or any successor entity.''.

(d) ROLE OF ASSOCIATE ADMINISTRATOR IN CARRYING OUT INTERNATIONAL TRADE POLICY.—Section 2(b)(1) of the Small Business Act (15 U.S.C. 631(b)(1)) is amended in the matter preceding subparagraph (A)—

(1) by inserting ''the Administrator of'' before ''the Small Business Administration''; and

(2) by inserting ''through the Associate Administrator for International Trade, and'' before ''in cooperation with''.

(e) IMPLEMENTATION DATE.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Small Business Administration shall appoint an Associate Administrator for International Trade under section 22(a) of the Small Business Act (15 U.S.C. 649(a)), as added by this section.

SEC. 4. DUTIES OF THE OFFICE OF INTERNATIONAL TRADE.

(a) AMENDMENTS TO SECTION 22.—Section 22 of the Small Business Act (15 U.S.C. 649) is amended—

(1) by striking subsection (b) and inserting the following:

''(b) TRADE DISTRIBUTION NETWORK.—The Associate Administrator, working in close cooperation with the Secretary of Commerce, the United States Trade Representative, the Export-Import Bank of the United States, the Overseas Private Investment Corporation, and other relevant Federal agencies, small business development centers engaged in export promotion efforts, Export Assistance Centers, regional and district offices of the Administration, the small business community, and relevant State and local export promotion programs, shall—

''(1) maintain a distribution network, using regional and district offices of the Administration, the small business development center network, networks of women's business centers, the Service Corps of Retired Executives authorized by section 8(b)(1), and Export Assistance Centers, for programs relating to—

''(A) trade promotion;

''(B) trade finance;

''(C) trade adjustment assistance;

''(D) trade remedy assistance; and

''(E) trade data collection;

''(2) aggressively market the programs described in paragraph (1) and disseminate information, including computerized marketing data, to small business concerns on exporting trends, market-specific growth, industry trends, and international prospects for exports;

''(3) promote export assistance programs through the district and regional offices of the Administration, the small business development center network, Export Assistance Centers, the network of women's business centers, chapters of the Service Corps of Retired Executives, State and local export promotion programs, and partners in the private sector; and

''(4) give preference in hiring or approving the transfer of any employee into the Office or to a position described in subsection (c)(9) to otherwise qualified applicants who are fluent in a language in addition to English, to—

''(A) accompany small business concerns on foreign trade missions; and

''(B) translate documents, interpret conversations, and facilitate multilingual transactions, including by providing referral lists for translation services, if required.'';

(2) in subsection (c)—

(A) by striking ''(c) The Office'' and inserting the following:

''(c) PROMOTION OF SALES OPPORTUNITIES.—The Associate Administrator'';

(B) by redesignating paragraphs (1) through (8) as paragraphs (2) through (9), respectively;

(C) by inserting before paragraph (2), as so redesignated, the following:

''(1) establish annual goals for the Office relating to—

''(A) enhancing the exporting capability of small business concerns and small manufacturers;

''(B) facilitating technology transfers;

''(C) enhancing programs and services to assist small business concerns and small manufacturers to compete effectively and efficiently against foreign entities;

''(D) increasing the ability of small business concerns to access capital;

''(E) disseminating information concerning Federal, State, and private programs and initiatives; and

''(F) ensuring that the interests of small business concerns are adequately represented in trade negotiations;'';

(D) in paragraph (2), as so redesignated, by striking ''mechanism for'' and all that follows through ''(D) assisting'' and inserting the following: ''mechanism for—

''(A) identifying subsectors of the small business community with strong export potential;

''(B) identifying areas of demand in foreign markets;

''(C) prescreening foreign buyers for commercial and credit purposes; and

''(D) assisting'';

(E) in paragraph (3), as so redesignated, by striking ''assist small businesses in the formation and utilization of'' and inserting ''assist small business concerns in forming and using'';

(F) in paragraph (4), as so redesignated—

(i) by striking ''local'' and inserting ''district'';

(ii) by striking ''existing'';

(iii) by striking ''Small Business Development Center network'' and inserting ''small business development center network''; and

(iv) by striking ''Small Business Development Center Program'' and inserting ''small business development center program'';

(G) in paragraph (5), as so redesignated—

(i) in subparagraph (A), by striking ''Gross State Produce'' and inserting ''Gross State Product'';

(ii) in subparagraph (B), by striking ''SIC'' each place it appears and inserting ''North American Industry Classification System''; and

(iii) in subparagraph (C), by striking ''small businesses'' and inserting ''small business concerns'';

(H) in paragraph (6), as so redesignated, by striking the period at the end and inserting a semicolon;

(I) in paragraph (7), as so redesignated—

(i) in the matter preceding subparagraph (A)—

(I) by inserting ''concerns'' after ''small business''; and

(II) by striking ''current'' and inserting ''up to date'';

(ii) in subparagraph (A), by striking ''Administration's regional offices'' and inserting ''regional and district offices of the Administration'';

(iii) in subparagraph (B) by striking ''current'';

(iv) in subparagraph (C), by striking ''current''; and

(v) by striking ''small businesses'' each place that term appears and inserting ''small business concerns'';

(J) in paragraph (8), as so redesignated, by striking and at the end;

(K) in paragraph (9), as so redesignated—

(i) in the matter preceding subparagraph (A)—

(I) by striking ''full-time export development specialists to each Administration regional office and assigning''; and

(II) by striking ''person in each district office. Such specialists'' and inserting ''individual in each district office and providing each Administration regional office with a full-time export development specialist, who'';

(ii) in subparagraph (B)—

(I) by striking ''current''; and

(II) by striking ''with'' and inserting ''in'';

(iii) in subparagraph (D)—

(I) by striking ''Administration personnel involved in granting'' and inserting ''personnel of the Administration involved in making''; and

(II) by striking ''and'' at the end;

(iv) in subparagraph (E)—

(I) by striking ''small businesses' needs'' and inserting ''the needs of small business concerns''; and

(II) by striking the period at the end and inserting a semicolon;

(v) by adding at the end the following:

''(F) participate, jointly with employees of the Office, in an annual training program that focuses on current small business needs for exporting; and

''(G) develop and conduct training programs for exporters and lenders, in cooperation with the Export Assistance Centers, the Department of Commerce, small business development centers, women's business centers, the Export-Import Bank of the United States, the Overseas Private Investment Corporation, and other relevant Federal agencies;''; and

(vi) by striking ''small businesses'' each place that term appears and inserting ''small business concerns''; and

(L) by adding at the end the following:

''(10) make available on the website of the Administration the name and contact information of each individual described in paragraph (9);

''(11) carry out a nationwide marketing effort using technology, online resources, training, and other strategies to promote exporting as a business development opportunity for small business concerns;

''(12) disseminate information to the small business community through regional and district offices of the Administration, the small business development center network, Export Assistance Centers, the network of women's business centers, chapters of the Service Corps of Retired Executives authorized by section 8(b)(1), State and local export promotion programs, and partners in the private sector regarding exporting trends, market-specific growth, industry trends, and prospects for exporting; and

''(13) establish and carry out training programs for the staff of the regional and district offices of the Administration and resource partners of the Administration on export promotion and providing assistance relating to exports.'';

(3) in subsection (d)—

(A) by redesignating paragraphs (1) through (5) as clauses (i) through (v), respectively, and adjusting the margins accordingly;

(B) by striking ''(d) The Office'' and inserting the following:

''(d) EXPORT FINANCING PROGRAMS.—

''(1) IN GENERAL.—The Associate Administrator''; and

(C) by striking ''To accomplish this goal, the Office shall work'' and inserting the following:

''(2) TRADE FINANCE SPECIALIST.—To accomplish the goal established under paragraph (1), the Associate Administrator shall—

''(A) designate at least 1 individual within the Administration as a trade finance specialist to oversee international loan programs and assist Administration employees with trade finance issues; and

''(B) work'';

(4) in subsection (e), by striking ''(e) The Office'' and inserting the following:

''(e) TRADE REMEDIES.—The Associate Administrator'';

(5) by amending subsection (f) to read as follows:

''(f) REPORTING REQUIREMENT.—The Associate Administrator shall submit an annual report to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives that contains—

''(1) a description of the progress of the Office in implementing the requirements of this section;

''(2) a detailed account of the results of export growth activities of the Administration, including the activities of each district and regional office of the Administration, based on the performance measures described in subsection (i);

''(3) an estimate of the total number of jobs created or retained as a result of export assistance provided by the Administration and resource partners of the Administration;

''(4) for any travel by the staff of the Office, the destination of such travel and the benefits to the Administration and to small business concerns resulting from such travel; and

''(5) a description of the participation by the Office in trade negotiations.'';

(6) in subsection (g), by striking ''(g) The Office'' and inserting the following:

''(g) STUDIES.—The Associate Administrator''; and

(7) by adding after subsection (h), as added by section 3 of this Act, the following:

''(i) EXPORT AND TRADE COUNSELING.—

''(1) DEFINITION.—In this subsection—

''(A) the term 'lead small business development center' means a small business development center that has received a grant from the Administration; and

''(B) the term 'lead women's business center' means a women's business center that has received a grant from the Administration.

''(2) CERTIFICATION PROGRAM.—The Administrator shall establish an export and trade counseling certification program to certify employees of lead small business development centers and lead women's business centers in providing export assistance to small business concerns.

''(3) NUMBER OF CERTIFIED EMPLOYEES.—The Administrator shall ensure that the number of employees of each lead small business development center who are certified in providing export assistance is not less than the lesser of—

''(A) 5; or

''(B) 10 percent of the total number of employees of the lead small business development center.

''(4) REIMBURSEMENT FOR CERTIFICATION.—

''(A) IN GENERAL.—Subject to the availability of appropriations, the Administrator shall reimburse a lead small business development center or a lead women's business center for costs relating to the certification of an employee of the lead small business center or lead women's business center in providing export assistance under the program established under paragraph (2).

''(B) LIMITATION.—The total amount reimbursed by the Administrator under subparagraph (A) may not exceed $350,000 in any fiscal year.

''(j) PERFORMANCE MEASURES.—

''(1) IN GENERAL.—The Associate Administrator shall develop performance measures for the Administration to support export growth goals for the activities of the Office under this section that include—

''(A) the number of small business concerns that—

''(i) receive assistance from the Administration;

''(ii) had not exported goods or services before receiving the assistance described in clause (i); and

''(iii) export goods or services;

''(B) the number of small business concerns receiving assistance from the Administration that export goods or services to a market outside the United States into which the small business concern did not export before receiving the assistance;

''(C) export revenues by small business concerns assisted by programs of the Administration;

''(D) the number of small business concerns referred to an Export Assistance Center or a small business development center by the staff of the Office;

''(E) the number of small business concerns referred to the Administration by an Export Assistance Center or a small business development center; and

''(F) the number of small business concerns referred to the Export-Import Bank of the United States or to the Overseas Private Investment Corporation by the staff of the Office, an Export Assistance Center, or a small business development center.

''(2) JOINT PERFORMANCE MEASURES.—The Associate Administrator shall develop joint performance measures for the district offices of the Administration and the Export Assistance Centers that include the number of export loans made under—

''(A) section 7(a)(16);

''(B) the Export Working Capital Program established under section 7(a)(14);

''(C) the Preferred Lenders Program, as defined in section 7(a)(2)(C)(ii); and

''(D) the export express program established under section 7(a)(34).

''(3) CONSISTENCY OF TRACKING.—The Associate Administrator, in coordination with the departments and agencies that are represented on the Trade Promotion Coordinating Committee established under section 2312 of the Export Enhancement Act of 1988 (15 U.S.C. 4727) and the small business development center network, shall develop a system to track exports by small business concerns, including information relating to the performance measures developed under paragraph (1), that is consistent with systems used by the departments and agencies and the network.''.

(b) TRADE DISPUTES.—The Administrator shall carry out a comprehensive program to provide technical assistance, counseling, and reference materials to small business concerns relating to resources, procedures, and requirements for mechanisms to resolve international trade disputes or address unfair international trade practices under international trade agreements or Federal law, including—

(1) directing the district offices of the Administration to provide referrals, information, and other services to small business concerns relating to the mechanisms;

(2) entering agreements and partnerships with providers of legal services relating to the mechanisms, to ensure small business concerns may affordably use the mechanisms; and

(3) in consultation with the Director of the United States Patent and Trademark Office and the Register of Copyrights, designing counseling services and materials for small business concerns regarding intellectual property protection in other countries.

(c) REPORT.—Not later than 60 days after the date of enactment of this Act, the Administrator shall submit a report to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives on any travel by the staff of the Office of International Trade of the Administration, during the period beginning on October 1, 2004, and ending on the date of enactment of the Act, including the destination of such travel and the benefits to the Administration and to small business concerns resulting from such travel.

SEC. 5. EXPORT ASSISTANCE CENTERS.

(a) EXPORT ASSISTANCE CENTERS.—Section 22 of the Small Business Act (15 U.S.C. 649), as amended by this Act, is amended by adding at the end the following:

''(k) EXPORT ASSISTANCE CENTERS.—

''(1) EXPORT FINANCE SPECIALISTS.—

''(A) MINIMUM NUMBER OF EXPORT FINANCE SPECIALISTS.—On and after January 1, 2010, the Administrator, in coordination with the Secretary of Commerce, shall ensure that the number of export finance specialists is not less than the number of such employees so assigned on January 1, 2003.

''(B) EXPORT FINANCE SPECIALISTS ASSIGNED TO EACH REGION OF THE ADMINISTRATION.—On and after the date that is 2 years after the date of enactment of this subsection, the Administrator, in coordination with the Secretary of Commerce, shall ensure that there are not fewer than 3 export finance specialists in each region of the Administration.

''(2) PLACEMENT OF EXPORT FINANCE SPECIALISTS.—

''(A) PRIORITY.—The Administrator shall give priority, to the maximum extent practicable, to placing employees of the Administration at any Export Assistance Center that—

''(i) had an Administration employee assigned to the Export Assistance Center before January 2003; and

''(ii) has not had an Administration employee assigned to the Export Assistance Center during the period beginning January 2003, and ending on the date of enactment of this subsection, either through retirement or reassignment.

''(B) NEEDS OF EXPORTERS.—The Administrator shall, to the maximum extent practicable, strategically assign Administration employees to Export Assistance Centers, based on the needs of exporters.

''(C) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed to require the Administrator to reassign or remove an export finance specialist who is assigned to an Export Assistance Center on the date of enactment of this subsection.

''(3) GOALS.—The Associate Administrator shall work with the Department of Commerce, the Export-Import Bank of the United States, and the Overseas Private Investment Corporation to establish shared annual goals for the Export Assistance Centers.

''(4) OVERSIGHT.—The Associate Administrator shall designate an individual within the Administration to oversee all activities conducted by Administration employees assigned to Export Assistance Centers.

''(l) DEFINITIONS.—In this section—

''(1) the term 'Associate Administrator' means the Associate Administrator for International Trade described in subsection (a)(2);

''(2) the term 'Export Assistance Center' means a one-stop shop for United States exporters established by the United States and Foreign Commercial Service of the Department of Commerce pursuant to section 2301(b)(8) of the Omnibus Trade and Competitiveness Act of 1988 (15 U.S.C. 4721(b)(8));

''(3) the term 'export finance specialist' means a full-time equivalent employee of the Office assigned to an Export Assistance Center to carry out the duties described in subsection (e); and

''(4) the term 'Office' means the Office of International Trade established under subsection (a)(1).''.

(b) STUDY AND REPORT ON FILLING GAPS IN HIGH-AND-LOW-EXPORT VOLUME AREAS.—

(1) STUDY AND REPORT.—Not later than 6 months after the date of enactment of this Act, and every 2 years thereafter, the Administrator shall—

(A) conduct a study of—

(i) the volume of exports for each State;

(ii) the availability of export finance specialists in each State;

(iii) the number of exporters in each State that are small business concerns;

(iv) the percentage of exporters in each State that are small business concerns;

(v) the change, if any, in the number of exporters that are small business concerns in each State—

(I) for the first study conducted under this subparagraph, during the 10-year period ending on the date of enactment of this Act; and

(II) for each subsequent study, during the 10-year period ending on the date the study is commenced;

(vi) the total value of the exports in each State by small business concerns;

(vii) the percentage of the total volume of exports in each State that is attributable to small business concerns; and

(viii) the change, if any, in the percentage of the total volume of exports in each State that is attributable to small business concerns—

(I) for the first study conducted under this subparagraph, during the 10-year period ending on the date of enactment of this Act; and

(II) for each subsequent study, during the 10-year period ending on the date the study is commenced; and

(B) submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report containing—

(i) the results of the study under subparagraph (A);

(ii) to the extent practicable, a recommendation regarding how to eliminate gaps between the supply of and demand for export finance specialists in the 15 States that have the greatest volume of exports, based upon the most recent data available from the Department of Commerce;

(iii) to the extent practicable, a recommendation regarding how to eliminate gaps between the supply of and demand for export finance specialists in the 15 States that have the lowest volume of exports, based upon the most recent data available from the Department of Commerce; and

(iv) such additional information as the Administrator determines is appropriate.

(2) DEFINITION.—In this subsection, the term ''export finance specialist'' has the meaning given that term in section 22(l) of the Small Business Act, as added by this Act.

SEC. 6. INTERNATIONAL TRADE FINANCE PROGRAMS.

(a) LOAN LIMITS.—

(1) TOTAL AMOUNT OUTSTANDING.—Section 7(a)(3)(B) of the Small Business Act (15 U.S.C. 636(a)(3)(B)) is amended by striking ''$1,750,000, of which not more than $1,250,000'' and inserting ''$4,500,000 (or if the gross loan amount would exceed $5,000,000), of which not more than $4,000,000''.

(2) PARTICIPATION.—Section 7(a)(2) of the Small Business Act (15 U.S.C. 636(a)(2)) is amended—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (D), and (E)'';

(B) in subparagraph (D), by striking ''Notwithstanding subparagraph (A), in'' and inserting ''In''; and

(C) by adding at the end the following:

''(E) PARTICIPATION IN INTERNATIONAL TRADE LOAN.—In an agreement to participate in a loan on a deferred basis under paragraph (16), the participation by the Administration may not exceed 90 percent.''.

(b) WORKING CAPITAL.—Section 7(a)(16)(A) of the Small Business Act (15 U.S.C. 636(a)(16)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''in—'' and inserting ''—'';

(2) in clause (i)—

(A) by inserting ''in'' after ''(i)''; and

(B) by striking ''or'' at the end;

(3) in clause (ii)—

(A) by inserting ''in'' after ''(ii)''; and

(B) by striking the period at the end and inserting '', including any debt that qualifies for refinancing under any other provision of this subsection; or''; and

(4) by adding at the end the following:

''(iii) by providing working capital.''.

(c) COLLATERAL.—Section 7(a)(16)(B) of the Small Business Act (15 U.S.C. 636(a)(16)(B)) is amended—

(1) by striking ''Each loan'' and inserting the following:

''(i) IN GENERAL.—Except as provided in clause (ii), each loan''; and

(2) by adding at the end the following:

''(ii) EXCEPTION.—A loan under this paragraph may be secured by a second lien position on the property or equipment financed by the loan or on other assets of the small business concern, if the Administrator determines the lien provides adequate assurance of the payment of the loan.''.

(d) EXPORT WORKING CAPITAL PROGRAM.—Section 7(a) of the Small Business Act (15 U.S.C. 636(a)) is amended—

(1) in paragraph (2)(D), by striking ''not exceed'' and inserting ''be''; and

(2) in paragraph (14)—

(A) by striking ''(A) The Administration'' and inserting the following: ''EXPORT WORKING CAPITAL PROGRAM.—

''(A) IN GENERAL.—The Administrator'';

(B) by striking ''(B) When considering'' and inserting the following:

''(C) CONSIDERATIONS.—When considering'';

(C) by striking ''(C) The Administration'' and inserting the following:

''(D) MARKETING.—The Administrator''; and

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

''(B) TERMS.—

''(i) LOAN AMOUNT.—The Administrator may not guarantee a loan under this paragraph of more than $5,000,000.

''(ii) FEES.—

''(I) IN GENERAL.—For a loan under this paragraph, the Administrator shall collect the fee assessed under paragraph (23) not more frequently than once each year.

''(II) UNTAPPED CREDIT.—The Administrator may not assess a fee on capital that is not accessed by the small business concern.''.

(e) PARTICIPATION IN PREFERRED LENDERS PROGRAM.—Section 7(a)(2)(C) of the Small Business Act (15 U.S.C. 636(a)(2)(C)) is amended—

(1) by redesignating clause (ii) as clause (iii); and

(2) by inserting after clause (i) the following:

''(ii) EXPORT-IMPORT BANK LENDERS.—Any lender that is participating in the Delegated Authority Lender Program of the Export-Import Bank of the United States (or any successor to the Program) shall be eligible to participate in the Preferred Lenders Program.''.

(f) EXPORT EXPRESS PROGRAM.—Section 7(a) of the Small Business Act (15 U.S.C. 636(a)) is amended—

(1) by striking ''(32) INCREASED VETERAN'' and inserting ''(33) INCREASED VETERAN''; and

(2) by adding at the end the following:

''(34) EXPORT EXPRESS PROGRAM.—

''(A) DEFINITIONS.—In this paragraph—

''(i) the term 'export development activity' includes—

''(I) obtaining a standby letter of credit when required as a bid bond, performance bond, or advance payment guarantee;

''(II) participation in a trade show that takes place outside the United States;

''(III) translation of product brochures or catalogues for use in markets outside the United States;

''(IV) obtaining a general line of credit for export purposes;

''(V) performing a service contract from buyers located outside the United States;

''(VI) obtaining transaction-specific financing associated with completing export orders;

''(VII) purchasing real estate or equipment to be used in the production of goods or services for export;

''(VIII) providing term loans or other financing to enable a small business concern, including an export trading company and an export management company, to develop a market outside the United States; and

''(IX) acquiring, constructing, renovating, modernizing, improving, or expanding a production facility or equipment to be used in the United States in the production of goods or services for export; and

''(ii) the term 'express loan' means a loan in which a lender uses to the maximum extent practicable the loan analyses, procedures, and documentation of the lender to provide expedited processing of the loan application.

''(B) AUTHORITY.—The Administrator may guarantee the timely payment of an express loan to a small business concern made for an export development activity.

''(C) LEVEL OF PARTICIPATION.—

''(i) MAXIMUM AMOUNT.—The maximum amount of an express loan guaranteed under this paragraph shall be $500,000.

''(ii) PERCENTAGE.—For an express loan guaranteed under this paragraph, the Administrator shall guarantee—

''(I) 90 percent of a loan that is not more than $350,000; and

''(II) 75 percent of a loan that is more than $350,000 and not more than $500,000.''.

(g) ANNUAL LISTING OF EXPORT FINANCE LENDERS.—Section 7(a)(16) of the Small Business Act (15 U.S.C. 636(a)(16)) is amended by adding at the end the following:

''(F) LIST OF EXPORT FINANCE LENDERS.—

''(i) PUBLICATION OF LIST REQUIRED.—The Administrator shall publish an annual list of the banks and participating lending institutions that, during the 1-year period ending on the date of publication of the list, have made loans guaranteed by the Administration under—

''(I) this paragraph;

''(II) paragraph (14); or

''(III) paragraph (34).

''(ii) AVAILABILITY OF LIST.—The Administrator shall—

''(I) post the list published under clause (i) on the website of the Administration; and

''(II) make the list published under clause (i) available, upon request, at each district office of the Administration.''.

(h) APPLICABILITY.—The amendments made by subsections (a) through (f) shall apply with respect to any loan made after the date of enactment of this Act.

SEC. 7. STATE TRADE AND EXPORT PROMOTION GRANT PROGRAM.

(a) DEFINITIONS.—In this section—

(1) the term ''eligible small business concern'' means a small business concern that—

(A) has been in business for not less than the 1-year period ending on the date on which assistance is provided using a grant under this section;

(B) is operating profitably, based on operations in the United States;

(C) has demonstrated understanding of the costs associated with exporting and doing business with foreign purchasers, including the costs of freight forwarding, customs brokers, packing and shipping, as determined by the Associate Administrator;

(D) has in effect a strategic plan for exporting; and

(E) agrees to provide to the Associate Administrator such information and documentation as is necessary for the Associate Administrator to determine that the small business concern is in compliance with the internal revenue laws of the United States;

(2) the term ''program'' means the State Trade and Export Promotion Grant Program established under subsection (b);

(3) the term ''small business concern owned and controlled by women'' has the meaning given that term in section 3 of the Small Business Act (15 U.S.C. 632);

(4) the term ''socially and economically disadvantaged small business concern'' has the meaning given that term in section 8(a)(4)(A) of the Small Business Act (15 U.S.C. 6537(a)(4)(A)); and

(5) the term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(b) ESTABLISHMENT OF PROGRAM.—The Associate Administrator shall establish a 3-year trade and export promotion pilot program to be known as the State Trade and Export Promotion Grant Program, to make grants to States to carry out export programs that assist eligible small business concerns in—

(1) participation in a foreign trade mission;

(2) a foreign market sales trip;

(3) a subscription to services provided by the Department of Commerce;

(4) the payment of website translation fees;

(5) the design of international marketing media;

(6) a trade show exhibition;

(7) participation in training workshops; or

(8) any other export initiative determined appropriate by the Associate Administrator.

(c) GRANTS.—

(1) JOINT REVIEW.—In carrying out the program, the Associate Administrator may make a grant to a State to increase the number of eligible small business concerns in the State that export or to increase the value of the exports by eligible small business concerns in the State.

(2) CONSIDERATIONS.—In making grants under this section, the Associate Administrator may give priority to an application by a State that proposes a program that—

(A) focuses on eligible small business concerns as part of an export promotion program;

(B) demonstrates success in promoting exports by—

(i) socially and economically disadvantaged small business concerns;

(ii) small business concerns owned or controlled by women; and

(iii) rural small business concerns;

(C) promotes exports from a State that is not 1 of the 10 States with the highest percentage of exporters that are small business concerns, based upon the latest data available from the Department of Commerce; and

(D) promotes new-to-market export opportunities to the People's Republic of China for eligible small business concerns in the United States.

(3) LIMITATIONS.—

(A) SINGLE APPLICATION.—A State may not submit more than 1 application for a grant under the program in any 1 fiscal year.

(B) PROPORTION OF AMOUNTS.—The total value of grants under the program made during a fiscal year to the 10 States with the highest percentage of exporters that are small business concerns, based upon the latest data available from the Department of Commerce, shall be not more than 50 percent of the amounts appropriated for the program for that fiscal year.

(4) APPLICATION.—A State desiring a grant under the program shall submit an application at such time, in such manner, and accompanied by such information as the Associate Administrator may establish.

(d) COMPETITIVE BASIS.—The Associate Administrator shall award grants under the program on a competitive basis.

(e) FEDERAL SHARE.—The Federal share of the cost of an export program carried out using a grant under the program shall be—

(1) for a State that has a high export volume, as determined by the Associate Administrator, not more than 65 percent; and

(2) for a State that does not have a high export volume, as determined by the Associate Administrator, not more than 75 percent.

(f) REPORTS.—

(1) INITIAL REPORT.—Not later than 120 days after the date of enactment of this Act, the Associate Administrator shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report, which shall include—

(A) a description of the structure of and procedures for the program;

(B) a management plan for the program; and

(C) a description of the merit-based review process to be used in the program.

(2) ANNUAL REPORTS.—The Associate Administrator shall submit an annual report to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives regarding the program, which shall include—

(A) the number and amount of grants made under the program during the preceding year;

(B) a list of the States receiving a grant under the program during the preceding year, including the activities being performed with grant; and

(C) the effect of each grant on exports by eligible small business concerns in the State receiving the grant.

(g) REVIEWS BY INSPECTOR GENERAL.—

(1) IN GENERAL.—The Inspector General of the Administration shall conduct a review of—

(A) the extent to which recipients of grants under the program are measuring the performance of the activities being conducted and the results of the measurements; and

(B) the overall management and effectiveness of the program.

(2) REPORT.—Not later than September 30, 2012, the Inspector General of the Administration shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report regarding the review conducted under paragraph (1).

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the program $15,000,000 for each of fiscal years 2010, 2011, and 2012.

(i) TERMINATION.—The authority to carry out the program shall terminate 3 years after the date on which the Associate Administrator establishes the program.

SEC. 8. RURAL EXPORT PROMOTION.

Not later than 6 months after the date of enactment of this Act, the Administrator, in consultation with the Secretary of Agriculture and the Secretary of Commerce, shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report that contains—

(1) a description of each program of the Administration that promotes exports by rural small business concerns, including—

(A) the number of rural small business concerns served by the program;

(B) the change, if any, in the number of rural small business concerns as a result of participation in the program during the 10-year period ending on the date of enactment of this Act;

(C) the volume of exports by rural small business concerns that participate in the program; and

(D) the change, if any, in the volume of exports by rural small businesses that participate in the program during the 10-year period ending on the date of enactment of this Act;

(2) a description of the coordination between programs of the Administration and other Federal programs that promote exports by rural small business concerns;

(3) recommendations, if any, for improving the coordination described in paragraph (2);

(4) a description of any plan by the Administration to market the international trade financing programs of the Administration through lenders that—

(A) serve rural small business concerns; and

(B) are associated with financing programs of the Department of Agriculture;

(5) recommendations, if any, for improving coordination between the counseling programs and export financing programs of the Administration, in order to increase the volume of exports by rural small business concerns; and

(6) any additional information the Administrator determines is necessary.

SEC. 9. INTERNATIONAL TRADE COOPERATION BY SMALL BUSINESS DEVELOPMENT CENTERS.

Section 21(a) of the Small Business Act (15 U.S.C. 648(a)) is amended—

(1) by striking ''(2) The Small Business Development Centers'' and inserting the following:

''(2) COOPERATION TO PROVIDE INTERNATIONAL TRADE SERVICES.—

''(A) INFORMATION AND SERVICES.—The small business development centers''; and

(2) in paragraph (2)—

(A) in subparagraph (A), as so designated, by inserting ''(including State trade agencies),'' after ''local agencies''; and

(B) by adding at the end the following:

''(B) COOPERATION WITH STATE TRADE AGENCIES AND EXPORT ASSISTANCE CENTERS.—A small business development center that counsels a small business concern on issues relating to international trade shall—

''(i) consult with State trade agencies and Export Assistance Centers to provide appropriate services to the small business concern; and

''(ii) as necessary, refer the small business concern to a State trade agency or an Export Assistance Center for further counseling or assistance.

''(C) DEFINITION.—In this paragraph, the term 'Export Assistance Center' has the same meaning as in section 22.''.

SEC. 10. SMALL BUSINESS TRADE POLICY.

(a) NOTIFICATION BY USTR.—Not later than 90 days before the United States Trade Representative begins a negotiation with regard to any trade agreement, the United States Trade Representative shall notify the Administrator of the date the negotiation will begin.

(b) RECOMMENDATIONS.—Not later than 30 days before the United States Trade Representative begins a negotiation with regard to any trade agreement, the Administrator shall present to the United States Trade Representative recommendations relating to the needs and concerns of small business concerns that are exporters.

Ms. LANDRIEU. Mr. President, as chair of the Committee on Small Business and Entrepreneurship, I am pleased to join the committee's ranking member, OLYMPIA SNOWE of Maine, in introducing the Small Business Export Enhancement and International Trade Act of 2009. Building upon legislation that I have introduced in the last three Congresses, including, S. 1196 the Small Business International Trade Enhancements Act of 2009 that I introduced in June of this year, this bipartisan legislation will ensure that small businesses seeking to export their goods and services will have access to the resources they need to successfully expand into foreign markets. With health premiums increasing more each year and cash registers at home not ringing like they used to, exporting has become a practical solution for small firms. Expanding opportunities for small business trade is not only vital to the financial security of our entrepreneurs, it is vital to the recovery of our economy.

Last year, $70 billion in exports maintained or created 600,000 high-paying American jobs. By creating jobs, as well as lessening the trade deficit, an increase in small business exporting will lead us out of this recession and make our nation better able to compete in the global marketplace. Furthermore, any investments we make in export programs will essentially pay for themselves. Every dollar invested in export programs increases exports by 40 percent, a World Bank study found.

In my home State of Louisiana, we have experienced firsthand the benefit of expanding and investing in export opportunities. With over 40 ports and an extensive rail system, Louisiana has long been a top destination for companies seeking to export their goods and services, particularly exporters. Despite the devastation caused by Hurricanes Katrina and Rita, Louisiana has experienced a tremendous growth in trade activity during the last five years, largely due to increased exports. For example, in 2008 alone, Louisiana exported nearly $41.9 billion dollars worth of goods and services, representing a 38-percent increase from 2007, more than triple the national export growth rate for that year.

However, while most of our Nation's exporters—about 97 percent—are small businesses, most of our small businesses are not exporting. In fact, small businesses make up just more than a quarter of the country's export volume—trade remains dominated by larger businesses. This is also true in Louisiana where, despite tremendous growth in exports in recent years, small businesses represent 85 percent of exporting companies, but account for only 30 percent of the export volume. What is holding our entrepreneurs back?

As chair of the Committee on Small Business and Entrepreneurship, I have heard from small exporters across the country. I held a roundtable on June 11—''Entrepreneurial Development: Investing in Small Businesses to Strengthen our Economy''—to hear from small business and exporting leaders. I also held a field hearing in New Orleans on June 30—''Keeping America Competitive: Federal Programs that Promote Small Business Exporting''—at which United States Trade Representative, Ambassador Ron Kirk, U.S. Small Business Administration, SBA, Administrator Karen Mills, U.S. Export-Import Bank Chairman and President Fred Hochberg and several small exporters testified. At these events, small exporters told me that the programs and services at the Small Business Administration, SBA, and other Federal agencies are helpful—but they are not doing everything they could and should do. Better coordination and improvements to the programs are needed.

Like many small businesses, one of the biggest hurdles faced by small exporters is access to capital. The current economic conditions exacerbate this problem for small firms. The SBA

offers several loan programs to help small exporters, but years of neglect under the previous administration have sometimes rendered these valuable tools both unattractive and impractical for borrowers and lenders alike.

One of these programs is the International Trade Loan, ITL, program. This program allows exporters to borrow up to $2 million with $1.75 million guaranteed by the SBA. Exporters can then use this money to help develop and expand overseas markets, upgrade equipment and facilities or provide an infusion of capital if they are being hurt by import competition.

While the original goal of this program is on target with the needs of larger exporters, it has not evolved to meet the financing needs of small exporters in an ever-changing global economy. The volume of loans made through this program has dropped by more than 90 percent since 2003. The SBA's other signature trade financing product—the Export Working Capital Program—has also seen a significant drop in its loan volume, declining by more than 31 percent over the same period.

With a few small but significant changes to these programs, the SBA will once again be able to provide a user friendly and attractive financing option that makes sense for both borrowers and lenders. For example, one of the biggest problems with the ITL program is a discrepancy between the loan cap and the guarantee, forcing borrowers to take out a second loan to take full advantage of the guarantee. Additionally, ITL's can only be used to acquire fixed assets, rather than working capital, a common need for exporters. ITL's also do not have the same collateral or refinancing terms as SBA 7(a) loans.

The provisions in this legislation, and previous versions of the legislation that I have introduced in the last three Congresses, address these concerns. The bill raises the loan guarantee to $4.5 million and the loan cap to $5 million, makes working capital an eligible use of proceeds, and extends the 7(a) program's terms for collateral and refinancing. The end result is a more relevant and more practical tool for small exporters.

By making these simple changes and requiring the agency to publish an annual list of all participating banks and lending institutions, the SBA's export finance programs will once again provide small exporters with the practical and modern financing options small businesses need and deserve. These programs, however, are only useful if a small business owner can identify which loan products are right for them. Local lenders that specialize in export financing can help get these products into the hands of the small exporters that need them the most, but they are not always the most effective ones to do so.

The SBA has 18 finance specialists posted at one-stop assistance centers throughout the country operated by the Department of Commerce. These specialists, at a minimal cost, have facilitated more than $10 billion in exports in the last 10 years, helping to create 140,000 new and higher paying jobs. Unfortunately, this program suffered staff cuts under the previous administration. Legislation that I introduced earlier this year, S. 1196, as well as other version of this legislation that I have introduced in previous Congresses, would restore the staffing levels to what they were in 2002, establishing a floor of 22 export finance specialists with priority staffing going to those centers who have been without a finance specialist since 2003. I am pleased that Ranking Member SNOWE has included language from my legislation establishing a minimum staffing level for the program and I applaud her efforts to expand the program at a realistic rate by requiring that no fewer than three export finance specialists are assigned to each SBA region within two years of enactment. I am also pleased that the bill includes language that I proposed, requiring the SBA to conduct a reoccurring, biannual study on the availability of export finance specialists in high and low export volume areas. This will ensure that future assignment of SBA personnel and resources are allocated to the areas with the greatest need.

With more than 20 federal agencies involved in export and trade promotion, small exporters often don't know where to turn for help, or even that help—like the local finance specialists—even exist. This legislation would help bring small business trade to the forefront in two ways:

First, it gives the SBA's Office of International Trade, OIT, more resources and a higher profile within the Agency, making it directly accountable to the Administrator instead of part of the Office of Capital Access, OCA, where it is currently housed. It also requires that OIT make numerous internal improvements by requiring the office to: maintain a trade information distribution network in partnership with other Federal agencies and SBA resource partners; properly staff and clarify the role of existing OIT positions in both regional and district offices; provide more coordinated training between employees of the office and lenders, small exporters and other resource partners; develop a comprehensive trade dispute technical assistance program; and finally, to develop targeted annual goals and performance metrics. OIT is doing an adequate job now, but with these proposed changes, the office would have the potential to become a more robust partner and visible advocate for small exporters seeking assistance from the SBA. I have long advocated for these simple yet important changes and I am pleased they made it into the final legislation.

In addition to improving the coordination and advocacy among Federal agencies and making needed changes to existing SBA resources, this bill seeks to increase the number of small businesses involved in exporting by using State resources more effectively. It does this by creating the State Trade and Export Promotion, STEP, program, a 3-year pilot grant program modeled after the SBA's successful SBIR-FAST program. Unlike existing Federal programs which tend to focus their resources in States that already possess a high percentage of small exporters or a large export volume, STEP seeks to reach small businesses in States with minimal export assistance resources to target businesses that typically do not export their goods and services. I have worked closely with the small business community in Louisiana and I believe that this program will have a tremendous impact not only in my State, but also nationally.

Finally, this legislation requires the SBA to report back to the committee on their efforts to promote exports to small businesses located in rural areas. With the technology that we posses today, there is no reason why a small business located in a rural or traditionally nonexporting area shouldn't have access to the same opportunities available to those located in urban, or high-export areas. Creating access to exporting opportunities for rural small businesses could lead to the creation of new jobs and increased development in these communities, especially in Louisiana. I am pleased this language was included in this bill.

The Small Business Export Enhancement and International Trade Act of 2009 is an important first step toward ensuring that small firms will have more opportunities to grow. By increasing exporting opportunities for small businesses, we will help them expand into international markets, create new and higher-paying jobs and strengthen the economy. I have heard from some of the members of my committee and I know how important this issue is to many of them, especially Ranking Member SNOWE whom I have worked closely with these past months to develop this comprehensive, bipartisan bill. I thank Senator SNOWE for her attention to this issue and strong willingness to make the changes our small exporters so desperately need.

The 111th Congress will be the third consecutive Congress that I have introduced or cosponsored legislation to help our small exporters. I introduced a version of this legislation in the 109th Congress as S.3663, in the 110th Congress as S. 738 and earlier this year as S. 1196. In these previous Congresses we have had some success in moving the provisions through committee, but as with other SBA reauthorization legislation, it stalled in the full Senate. As the new chair of the Committee on Small Business and Entrepreneurship this Congress, I have made increasing small business export opportunities one of the committee's top priorities and will continue to do so in the future. I am pleased to join Ranking

Member SNOWE in introducing this legislation and will continue to work closely with her and other members of the committee in the coming months to bring this legislation to the President's desk.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 373—DESIGNATING THE MONTH OF FEBRUARY 2010 AS ''NATIONAL TEEN DATING VIOLENCE AWARENESS AND PREVENTION MONTH''

Mr. CRAPO (for himself and Mr. LIEBERMAN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 373

Whereas dating, domestic, and sexual violence affect women regardless of their age, and teens and young women are especially vulnerable;

Whereas, approximately 1 in 3 adolescent girls in the United States is a victim of physical, emotional, or verbal abuse from a dating partner, a figure that far exceeds victimization rates for other types of violence affecting youth;

Whereas nationwide, 1 in 10 high school students (9.9 percent) has been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend;

Whereas more than 1 in 4 teenagers have been in a relationship where a partner is verbally abusive;

Whereas 20 percent of teen girls exposed to physical dating violence did not attend school because the teen girls felt unsafe either at school, or on the way to or from school, on 1 or more occasions in a 30-day period;

Whereas violent relationships in adolescence can have serious ramifications for victims by putting the victims at higher risk for substance abuse, eating disorders, risky sexual behavior, suicide, and adult revictimization;

Whereas being physically and sexually abused leaves teen girls up to 6 times more likely to become pregnant and more than 2 times as likely to report a sexually transmitted disease;

Whereas nearly 3 in 4 children ages 11 to 14 (referred to in this preamble as ''tweens''), say that dating relationships usually begin at age 14 or younger and about 72 percent of eighth and ninth graders report ''dating'';

Whereas 1 in 5 tweens say their friends are victims of dating violence and nearly ½ of tweens who are in relationships know friends who are verbally abused;

Whereas more than 3 times as many tweens (20 percent) as parents of tweens (6 percent) admit that parents know little or nothing about the dating relationships of tweens;

Whereas teen dating abuse most often takes place in the home of 1 of the partners;

Whereas a majority of parents surveyed believe they have had a conversation with their teen about what it means to be in a healthy relationship, but the majority of teens surveyed said that they have not had a conversation about dating abuse with a parent in the past year;

Whereas digital abuse and ''sexting'' is becoming a new frontier for teen dating abuse;

Whereas 1 in 4 teens in a relationship say they have been called names, harassed, or put down by their partner through cellphones and texting;

Whereas 3 in 10 young people have sent or received nude pictures of other young people on their cell or online, and 61 percent who have ''sexted'' report being pressured to do so at least once;

Whereas targets of digital abuse are almost 3 times as likely to contemplate suicide as those who haven not encountered such abuse (8 percent vs. 3 percent), and targets of digital abuse are nearly 3 times more likely to have considered dropping out of school;

Whereas the severity of violence among intimate partners has been shown to be greater in cases where the pattern of violence has been established in adolescence;

Whereas primary prevention programs are a key part of addressing teen dating violence and many successful community examples include education, community outreach, and social marketing campaigns that also understand the cultural appropriateness of programs;

Whereas skilled assessment and intervention programs are also necessary for youth victims and abusers; and

Whereas the establishment of National Teen Dating Violence Awareness and Prevention Month will benefit schools, communities, and families regardless of socioeconomic status, race, or sex: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of February 2010, as ''National Teen Dating Violence Awareness and Prevention Month'';

(2) supports communities to empower teens to develop healthier relationships; and

(3) calls upon the people of the United States, including youth and parents, schools, law enforcement, State and local officials, and interested groups to observe National Teen Dating Violence Awareness and Prevention Month with appropriate programs and activities that promote awareness and prevention of the crime of teen dating violence in their communities.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3079. Mr. ROBERTS (for himself and Mr. INHOFE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3080. Mr. ENSIGN (for himself and Mr. COBURN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3081. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3082. Mr. BURR (for himself and Mr. ROBERTS) 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 3083. Mr. BURR 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 3084. Mr. AKAKA (for himself, Mr. INOUYE, Mrs. LINCOLN, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3085. Mrs. LINCOLN (for herself, Mr. DURBIN, Mr. KERRY, Ms. LANDRIEU, and Mr. BAYH) 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 3086. Ms. CANTWELL (for herself and Mr. KOHL) 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 3087. Mr. CORKER 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 3088. Ms. COLLINS (for herself and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3089. Mr. BENNETT 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 3090. Mr. BENNETT 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 3091. Mr. BENNETT 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 3092. Mr. BENNETT 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 3093. Mr. BENNETT 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 3094. Mr. BENNETT 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 3095. Mr. BENNETT 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 3096. Mr. BENNETT 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 3097. Mr. KYL 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 3098. Mr. CASEY (for himself and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786

proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3099. 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 3100. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3101. Mr. FRANKEN 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 3102. Mr. DURBIN (for himself 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 3103. Mr. CARPER 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 3104. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3105. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3106. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3107. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3108. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3109. Mr. AKAKA 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 3110. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3111. Mr. SESSIONS 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 3112. Ms. CANTWELL (for herself, Ms. SNOWE, Ms. LANDRIEU, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3113. Mr. SPECTER 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 3114. Mr. GRASSLEY (for himself, Mr. COBURN, Mr. BROWNBACK, Mr. CHAMBLISS, Mr. ISAKSON, Ms. MURKOWSKI, Mr. BUNNING, Mr. BENNETT, Mr. LEMIEUX, Mr. BARRASSO, and Mr. ENZI) 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 3079. Mr. ROBERTS (for himself and Mr. INHOFE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1997, strike line 1 and all that follows through page 1998, line 12.

SA 3080. Mr. ENSIGN (for himself and Mr. COBURN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 152, after line 24, add the following:

(l) PUBLIC REPORTING OF PATIENT WAIT TIMES.—

(1) IN GENERAL.—A qualified health plan offered through the Exchange, including the community health insurance option under section 1323 and any other health insurance option established under this Act, shall collect and make available on an Internet website a description of—

(A) the average waiting times (between diagnosis and treatment), listed by individual hospital and health care provider, for specific health care items or services covered under the plan or option, including—

(i) general surgery;

(ii) cancer surgery;

(iii) cardiac procedures;

(iv) ophthalmic surgery;

(v) orthopedic surgery; and

(vi) diagnostic scans; and

(B) the average waiting times that patients are in an emergency room being diagnosed, receiving treatment, or waiting for admission to a hospital bed under the plan or option.

(2) ANNUAL UPDATES.—A qualified health plan offered through the Exchange, including the community health insurance option under section 1323 and any other health insurance option established under this Act, shall annually update the information made available under paragraph (1).

SA 3081. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 271, between lines 15 and 16, insert the following:

For purposes of this section, the term ''social security number'' means a social security number issued to an individual by the Social Security Administration. Such term shall not include a taxpayer identification number or TIN issued by the Internal Revenue Service.

SA 3082. Mr. BURR (for himself and Mr. ROBERTS) 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 1999, strike lines 1 through 20 and insert the following:

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (k) and (l), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $5,000 made to such arrangement.

''(2) ADJUSTMENT FOR MEDICAL INFLATION.—In the case of any taxable year beginning after December 31, 2010, the dollar amount in paragraph (1) shall be increased by the medical care cost adjustment of such amount (within the meaning of section 213(d)(10)(B)(ii)) for the calendar year in which such taxable year begins. If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

(b) MODIFICATION OF REIMBURSEMENT RULES.—Section 106 of the Internal Revenue Code of 1986, as amended by section 9003, is amended by striking subsection (f).

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2009.

(2) REIMBURSEMENT.—The amendment made by subsection (b) shall apply in the same manner as the amendment made by section 9003(c).

SEC. 9006. LIMITATION ON DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986, as amended by section 9005, is amended by inserting after subsection (i) the following new subsection:

''(j) INDEXING OF LIMITATION ON DEPENDENT CARE FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a dependent care flexible spending arrangement in a taxable year beginning after calendar year 2010, the dollar amount of the limitation under section 129(2)(A) which applies to such flexible spending arrangement shall be increased by an amount equal to—

''(1) such dollar amount, multiplied by

''(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins, determined by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3083. Mr. BURR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title V, insert the following:

SEC. ___. DEFINITION OF ECONOMIC HARDSHIP.

(a) IN GENERAL.—Section 435(o) of the Higher Education Act of 1965 (20 U.S.C. 1085(o)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)(ii), by striking ''or'' after the semicolon;

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

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

''(B) such borrower is working full-time and has a Federal educational debt burden that equals or exceeds 20 percent of such borrower's adjusted gross income, and the difference between such borrower's adjusted gross income minus such burden is less than 220 percent of the greater of—

''(i) the annual earnings of an individual earning the minimum wage under section 6 of the Fair Labor Standards Act of 1938; or

''(ii) 150 percent of the poverty line, as defined under section 673(2) of the Community Services Block Grant Act, applicable to such borrower's family size; or''; and

(2) in paragraph (2), by striking ''(1)(B)'' and inserting ''(1)(C)''.

(b) FUNDING.—The Secretary of Health and Human Services shall transfer to the Secretary of Education, from amounts appropriated to the Prevention and Public Health Fund under section 4002, amounts necessary to carry out the amendments made by this section.

SA 3084. Mr. AKAKA (for himself, Mr. INOUYE, Mrs. LINCOLN, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. MEDICAID ELIGIBILITY FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the program defined in paragraph (3)(C) (relating to medicaid), paragraph (1) shall not apply to any individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with—

''(i) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Federated States of Micronesia, approved by Congress in the Compact of Free Association Amendments Act of 2003;

''(ii) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Republic of the Marshall Islands, approved by Congress in the Compact of Free Association Amendments Act of 2003; or

''(iii) section 141 of the Compact of Free Association between the Government of the United States and the Government of Palau, approved by Congress in Public Law 99–658 (100 Stat. 3672).''.

(b) QUALIFIED ALIEN.—Section 431(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is amended—

(1) in paragraph (6), by striking ''or'' at the end;

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(8) an individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with a Compact of Free Association referred to in section 402(b)(2)(G).''.

(c) CONFORMING AMENDMENTS.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), in the matter preceding paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)''; and

(2) by adding at the end the following:

''(h) The limitations of subsections (f) and (g) shall not apply with respect to medical assistance provided to an individual described in section 431(b)(8) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this Act and apply to benefits and assistance provided on or after that date.

SA 3085. Mrs. LINCOLN (for herself, Mr. DURBIN, Mr. KERRY, Ms. LANDRIEU, and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

SEC. 9024. INCREASE IN SMALL BUSINESS TAX CREDIT AVERAGE ANNUAL WAGE THRESHOLD.

(a) IN GENERAL.—Subparagraph (B) of section 45R(d)(3)(B) of the Internal Revenue Code of 1986, as added by section 1421(a), is amended by striking ''$20,000'' both places it appears and inserting ''$25,000''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 1421.

SA 3086. Ms. CANTWELL (for herself and Mr. KOHL) 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 492, between lines 15 and 16, insert the following:

SEC. 2407. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and increased under section 1902(gg)(5) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f))(1)) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

(c) CONDITIONS.—The conditions described in this subsection are the following:

(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

(A) a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph

(2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a ''no wrong door - single entry point system'', optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

(2) TARGET SPENDING PERCENTAGES.—

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for home and community-based services under the State Medicaid program for fiscal year 2009 are for such services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for home and community-based services under the State Medicaid program are for such services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for home and community-based services under the State Medicaid program are for such services.

(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

(A) ''NO WRONG DOOR''—SINGLE ENTRY POINT SYSTEM.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, and referral services for services and supports otherwise available in the community ; and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports, for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

(i) measures of beneficiary and family caregiver experience with providers;

(ii) measures of beneficiary and family caregiver satisfaction with services; and

(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

(2) in the case of any other balancing incentive payment State, 2 percentage points.

(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed $3,000,000,000.

(f) DEFINITIONS.—In this section:

(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term ''long-term services and supports'' has the meaning given that term by Secretary and may include any of the following (as defined with for purposes of State Medicaid programs under title XIX of the Social Security Act):

(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

(i) Nursing facility services.

(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:

(i) Home and community-based services provided under subsection (c), (d), or (i), of section 1915 of such Act or under a waiver under section 1115 of such Act.

(ii) Home health care services.

(iii) Personal care services.

(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).

(v) Self-directed personal assistance services described in section 1915(j) of such Act.

(2) BALANCING INCENTIVE PERIOD.—The term ''balancing incentive period'' means the period that begins on October 1, 2011, and ends on September 30, 2015.

(3) POVERTY LINE.—The term ''poverty line'' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(4) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

SA 3087. Mr. CORKER 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. ___. REQUIRING MEMBERS OF CONGRESS TO ACCEPT THE SAME CHOICES FOR HEALTH INSURANCE COVERAGE AS THOSE GIVEN TO AMERICAN CITIZENS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.

(a) FINDINGS.—Congress makes the following findings:

(1) Congress has stated that health care reform legislation should ensure all Americans have choices of affordable, quality health insurance coverage.

(2) Americans have overwhelmingly voiced their desire to receive the same types of choices for health insurance coverage that Members of Congress receive.

(3) This Act and the amendments made by this Act are estimated to place nearly half of the newly insured in a government program without the choices of private coverage that individuals with income above 133 percent of the poverty line receive.

(4) This Act provides legal immigrants with income at or below 133 percent of the poverty line with a choice of private coverage while American citizens with income at or below 133 percent of the poverty line have no choice of private coverage.

(b) MEMBERS OF CONGRESS REQUIRED TO HAVE COVERAGE UNDER MEDICAID.—

(1) IN GENERAL.—The Director of the Office of Personnel Management shall, in consultation with the Secretary of Health and Human Services, ensure that, on and after January 1, 2014, notwithstanding chapter 89 of title 5, United States Code, title XIX of the Social Security Act, or any provision of this Act—

(A) each Member of Congress shall be eligible for medical assistance under the Medicaid plan of the State in which the Member resides; and

(B) any employer contribution under chapter 89 of title 5 of such Code on behalf of the

Member may be paid only to the State agency responsible for administering the Medicaid plan in which the Member enrolls and not to the offeror of a plan offered through the Federal employees health benefit program under such chapter.

(2) PAYMENTS BY FEDERAL GOVERNMENT.—The Secretary of Health and Human Services, in consultation with the Director of the Office of Personnel Management, shall establish procedures under which the employer contributions that would otherwise be made on behalf of a Member of Congress if the Member were enrolled in a plan offered through the Federal employees health benefit program may be made directly to the State agencies described in paragraph (1)(B).

(3) INELIGIBLE FOR FEHBP.—Effective January 1, 2014, no Member of Congress shall be eligible to obtain health insurance coverage under the program chapter 89 of title 5, United States Code.

(4) DEFINITION.—In this section, the term ''Member of Congress'' means any member of the House of Representatives or the Senate.

SA 3088. Ms. COLLINS (for herself and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1265, between lines 8 and 9, insert the following:

SEC. 4307. ASSESSMENT OF MEDICARE COST-INTENSIVE DISEASES AND CONDITIONS.

(a) INITIAL ASSESSMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program under title XVIII of the Social Security Act and, to the extent possible, assess the diseases and conditions that could become cost-intensive for the Medicare program in the future.

(2) REPORT.—Not later than January 1, 2011, the Secretary shall transmit a report to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions, Finance, and Appropriations of the Senate on the assessment conducted under paragraph (1). Such report shall—

(A) include the assessment of current and future trends of cost-intensive diseases and conditions described in such paragraph;

(B) address whether current research priorities are appropriately addressing current and future cost-intensive conditions so identified;

(C) include the input of relevant research agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Food and Drug Administration; and

(D) include recommendations concerning research in the Department of Health and Human Services that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions.

(b) UPDATES OF ASSESSMENT.—Not later than January 1, 2013, and biennially thereafter, the Secretary shall—

(1) review and update the assessment and recommendations described in subsection (a)(1); and

(2) submit a report described in subsection (a)(2) to the Committees specified in subsection (a)(2) on such updated assessment and recommendations.

(c) CMS MEDICARE COST-INTENSIVE RESEARCH FUND.—

(1) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the ''CMS Medicare Cost-Intensive Research Fund'', in this subsection referred to as the ''Fund''. The Administrator of the Centers for Medicare & Medicaid Services shall administer the Fund. The Fund shall consist of such amounts as may be appropriated or credited to such Fund for the purposes described in paragraph (2). The Administrator shall not transfer appropriations to or from other relevant research agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Food and Drug Administration.

(2) PURPOSES OF FUND.—From amounts in the Fund, the Administrator of the Centers for Medicare & Medicaid Services shall make available, without further appropriation, grants, contracts, and other funding mechanisms, as recommended by the reports under this subsection, to facilitate research into the prevention, treatment, or cure of cost-intensive diseases and conditions under the Medicare program.

SA 3089. Mr. BENNETT 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. ___. PRESERVATION OF MEDICARE.

Notwithstanding any other provision of this Act (or an amendment made by this Act), the amendments made by title III to expand Medicare eligibility under title XVIII of the Social Security Act shall not take effect until the Secretary certifies to Congress that premiums assessed for coverage under non-Federal health insurance coverage will not increase in any manner to compensate for lower premiums assessed under the Medicare program.

SA 3090. Mr. BENNETT 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 102, strike line 19 and all that follows through line 6 on page 108, and insert the following:

(a) NO DEFINITION BY SECRETARY OF ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or any amendment made by this Act), in no case shall the Secretary define the benefit categories required for essential health benefits or specify the covered treatments, items, and services within such categories through regulations or other guidance.

(2) AUTHORITY BY STATES.—Nothing in this section shall be construed to limit the ability of States to define benefit categories or specific covered treatments, items, and services within such categories.

(b) RULE OF CONSTRUCTION.—Nothing in this

SA 3091. Mr. BENNETT submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 348, strike line 16 and all that follows through line 17 on page 357.

SA 3092. Mr. BENNETT submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of section 1323, insert the following:

(i) LIMITATION.—Notwithstanding any other provision of this section, the Secretary shall ensure that no coverage is offered under this section until such time as the Secretary certifies that premiums assessed for qualified health plans will not increase in any manner to compensate for lower premiums assessed under the coverage described under this section.

SA 3093. Mr. BENNETT 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. ___. LIMITATION ON NEW ENTITLEMENT SPENDING.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no entitlement program established under this Act (or amendments) shall be implemented until the Secretary of the Treasury certifies to Congress that total Federal mandatory spending will not exceed total Federal outlays for the first 5 years of the implementation of this Act.

SA 3094. Mr. BENNETT 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. ___. LIMITATION ON NEW ENTITLEMENT SPENDING.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no entitlement program established under this Act (or amendments) shall be implemented until the Secretary of the Treasury certifies to Congress that total Federal revenues exceed total Federal outlays.

SA 3095. Mr. BENNETT 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. ___. LIMITATION ON ENTITLEMENT SPENDING.

(a) CERTIFICATION.—Notwithstanding any other provision of this Act, this Act (and the amendments made by this Act) shall not take effect until the Secretary of the Treasury certifies to Congress that entitlement spending for the Medicare, Medicaid, and Social Security programs under titles XVIII, XIX, or II of the Social Security Act, and spending under other new entitlement programs provided for in this Act will not exceed 10 percent of the Gross Domestic Product (as estimated by the Secretary of Commerce) between fiscal years 2014 and 2019.

(b) TERMINATION.—If the Secretary of the Treasury at any time determines that the spending referred to in subsection (a) exceeds 10 percent of the Gross Domestic Program during any of fiscal years 2014 through 2019, new entitlement spending programs provided for under this Act shall not be implemented.

SA 3096. Mr. BENNETT 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. ___. IMPLEMENTATION OF MANDATORY SPENDING PROGRAMS.

(a) IN GENERAL.—If Federal mandatory spending (minus interest expense) exceeds 50 percent of Federal outlays in a fiscal year, it shall not be in order in the Senate or the House of Representatives to consider any legislation resulting in new mandatory spending for such fiscal year or any fiscal year thereafter until such spending is less than 50 percent of such outlays for a fiscal year.

(b) WAIVER.—This section may be waived or suspended in the Senate or House of Representatives only by an affirmative vote of 3/5 of the members, duly chosen and sworn.

(c) APPEAL.—An affirmative vote of 3/5 of the members of the Senate or House of Representatives, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

SA 3097. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___—MEDICAL LIABILITY REFORM

SEC. ___1. SHORT TITLE.

This title may be cited as the ''Medical Liability Reform Act of 2009''.

SEC. ___2. FINDINGS.

Congress makes the following findings:

(1) Medical liability laws create a significant portion of the overall costs of health care, and contribute to Americans' lack of access to health care.

(2) A 2006 study by PriceWaterhouse Coopers found that medical liability laws and the practice of defensive medicine contribute to 10 percent of all health care costs.

(3) The non-partisan Congressional Budget Office estimated that the Federal Government could directly save about $5,600,000,000 by enacting certain medical liability reforms, and that total health care spending could be reduced even further if these reforms reduced the practice of defensive medicine.

(4) According to economists Daniel P. Kessler and Mark B. McClellan, defensive medicine alone costs Americans more than $100,000,000,000 every year.

(5) Medicaid and Medicare costs must be lowered to keep these crucial programs solvent.

(6) In part because of the costs of medical liability, 40 percent of physicians refuse to see new Medicaid patients.

(7) Reform of the medical liability laws has been proven to increase access to doctors and specialists while lowering health care costs.

(8) In 2003, Texas adopted medical liability reforms that placed a cap on non-economic damages in medical liability cases and combated junk science by raising the standards of qualification for expert witnesses.

(9) After Texas passed this reform, premiums for medical malpractice liability insurance fell by 27 percent on average, and in some cases, by more than 50 percent.

(10) Because the Texas reforms led to more affordable health insurance premiums, more than 400,000 additional Texans are covered by health insurance than if reform had not passed.

(11) Because of the Texas reforms, Texas saw an overall growth rate of 31 percent in the number of new physicians.

(12) The growth rate in the number of physicians in Texas was particularly pronounced in long-underserved geographic areas such as the rural and border regions, and in key specialties such as obstetrics, neurosurgery, and orthopedic surgery.

(13) Arizona adopted medical liability reforms that deterred frivolous litigation by requiring expert opinion testimony at the threshold of medical liability suits and by raising the standards of qualification for expert witnesses.

(14) The health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(15) The health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

SEC. ___3. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(4) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(5) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(6) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not

limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this title, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. ___4. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. ___5. ENSURING RELIABLE EXPERT TESTIMONY.

(a) EXPERT WITNESS QUALIFICATIONS.—

(1) IN GENERAL.—In any health care lawsuit, an individual shall not give expert testimony on the appropriate standard of practice or care involved unless the individual is licensed as a health professional in 1 or more States and the individual meets the following criteria:

(A) If the party against whom or on whose behalf the testimony is to be offered is or claims to be a specialist, the expert witness shall specialize at the time of the occurrence that is the basis for the lawsuit in the same specialty or claimed specialty as the party against whom or on whose behalf the testimony is to be offered. If the party against whom or on whose behalf the testimony is to be offered is or claims to be a specialist who is board certified, the expert witness shall be a specialist who is board certified in that specialty or claimed specialty.

(B) During the 1-year period immediately preceding the occurrence of the action that gave rise to the lawsuit, the expert witness shall have devoted a majority of the individual's professional time to one or more of the following:

(i) The active clinical practice of the same health profession as the defendant and, if the defendant is or claims to be a specialist, in the same specialty or claimed specialty.

(ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession as the defendant and, if the defendant is or claims to be a specialist, in an accredited health professional school or accredited residency or clinical research program in the same specialty or claimed specialty.

(C) If the defendant is a general practitioner, the expert witness shall have devoted a majority of the witness's professional time in the 1-year period preceding the occurrence of the action giving rise to the lawsuit to one or more of the following:

(i) Active clinical practice as a general practitioner.

(ii) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession as the defendant.

(2) HEALTH CARE INSTITUTIONS.—If the defendant in a health care lawsuit is a health care institution that employs a health professional against whom or on whose behalf the testimony is offered, the provisions of paragraph (1) apply as if the health professional were the party or defendant against whom or on whose behalf the testimony is offered.

(3) POWER OF COURT.—Nothing in this subsection shall limit the power of the trial court in a health care lawsuit to disqualify an expert witness on grounds other than the qualifications set forth under this subsection.

(4) LIMITATION.—An expert witness in a health care lawsuit shall not be permitted to testify if the fee of the witness is in any way contingent on the outcome of the lawsuit.

(b) PRELIMINARY EXPERT OPINION TESTIMONY AGAINST HEALTH CARE PROFESSIONALS.—

(1) CERTIFICATION.—In any health care lawsuit, the claimant (or its attorney) shall certify in a written statement that is filed and served with the claim whether or not expert opinion testimony is necessary to prove the health care professional's standard of care or liability for the claim.

(2) PRELIMINARY EXPERT OPINION.—

(A) IN GENERAL.—If the claimant in any health care lawsuit certifies that expert opinion testimony is necessary as required under paragraph (1), the claimant shall serve a preliminary expert opinion affidavit. The claimant may provide affidavits from as many experts as the claimant determines to be necessary.

(B) REQUIREMENTS.—A preliminary expert opinion affidavit under subparagraph (A)

shall contain at least the following information:

(i) The expert's qualifications to express an opinion on the health care professionals standard of care or liability for the claim.

(ii) The factual basis for each claim against a health care professional.

(iii) The health care professional's acts, errors or omissions that the expert considers to be a violation of the applicable standard of care resulting in liability.

(iv) The manner in which the health care professional's acts, errors, or omissions caused or contributed to the damages or other relief sought by the claimant.

(3) DISPUTES.—If the claimant in any health care lawsuit or its attorney certifies that expert testimony is not required for the claim and the defendant disputes that certification in good faith, the defendant may apply by motion to the court for an order requiring the claimant to obtain and serve a preliminary expert opinion affidavit under this subsection, and such motion may be granted by the court.

(4) DISMISSALS.—The court in a health care lawsuit, on its own motion or the motion of the defendant, shall dismiss the claim against the defendant without prejudice if the claimant fails to file and serve a preliminary expert opinion affidavit after the claimant (or its attorney) has certified that an affidavit is necessary or the court has ordered the claimant to file and serve an affidavit.

SEC. ___6. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. ___7. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter provides for a greater amount of damages than provided in this title.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section ___4(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. ___8. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act.

SA 3098. Mr. CASEY (for himself and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN

SEC. __001. DEFINITIONS.

In this title:

(1) ACCOMPANIMENT.—The term ''accompaniment'' means assisting, representing, and accompanying a woman in seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, and may include the payment of court costs and reasonable attorney and witness fees associated therewith.

(2) ELIGIBLE INSTITUTION OF HIGHER EDUCATION.—The term ''eligible institution of higher education'' means an institution of higher education (as such term is defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)) that has established and operates, or agrees to establish and operate upon the receipt of a grant under this title, a pregnant and parenting student services office.

(3) COMMUNITY SERVICE CENTER.—The term ''community service center'' means a nonprofit organization that provides social services to residents of a specific geographical area via direct service or by contract with a local governmental agency.

(4) HIGH SCHOOL.—The term ''high school'' means any public or private school that operates grades 10 through 12, inclusive, grades 9 through 12, inclusive or grades 7 through 12, inclusive.

(5) INTERVENTION SERVICES.—The term ''intervention services'' means, with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour telephone hotline services for police protection and referral to shelters.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) STATE.—The term ''State'' includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.

(8) SUPPORTIVE SOCIAL SERVICES.—The term ''supportive social services'' means transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

(9) VIOLENCE.—The term ''violence'' means actual violence and the risk or threat of violence.

SEC. __002. ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND.

(a) IN GENERAL.—The Secretary, in collaboration and coordination with the Secretary of Education (as appropriate), shall establish a Pregnancy Assistance Fund to be administered by the Secretary, for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women.

(b) USE OF FUND.—A State may apply for a grant under subsection (a) to carry out any activities provided for in section __003.

(c) APPLICATIONS.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the purposes for which the grant is being requested and the designation of a State agency for receipt and administration of funding received under this title.

SEC. __003. PERMISSIBLE USES OF FUND.

(a) IN GENERAL.—A State shall use amounts received under a grant under section __001 for the purposes described in this section to assist pregnant and parenting teens and women.

(b) INSTITUTIONS OF HIGHER EDUCATION.—

(1) IN GENERAL.—A State may use amounts received under a grant under section __001 to make funding available to eligible institutions of higher education to enable the eligible institutions to establish, maintain, or operate pregnant and parenting student services. Such funding shall be used to supplement, not supplant, existing funding for such services.

(2) APPLICATION.—An eligible institution of higher education that desires to receive funding under this subsection shall submit an application to the designated State agency at such time, in such manner, and containing such information as the State agency may require.

(3) MATCHING REQUIREMENT.—An eligible institution of higher education that receives

funding under this subsection shall contribute to the conduct of the pregnant and parenting student services office supported by the funding an amount from non-Federal funds equal to 25 percent of the amount of the funding provided. The non-Federal share may be in cash or in-kind, fairly evaluated, including services, facilities, supplies, or equipment.

(4) USE OF FUNDS FOR ASSISTING PREGNANT AND PARENTING COLLEGE STUDENTS.—An eligible institution of higher education that receives funding under this subsection shall use such funds to establish, maintain or operate pregnant and parenting student services and may use such funding for the following programs and activities:

(A) Conduct a needs assessment on campus and within the local community—

(i) to assess pregnancy and parenting resources, located on the campus or within the local community, that are available to meet the needs described in subparagraph (B); and

(ii) to set goals for—

(I) improving such resources for pregnant, parenting, and prospective parenting students; and

(II) improving access to such resources.

(B) Annually assess the performance of the eligible institution in meeting the following needs of students enrolled in the eligible institution who are pregnant or are parents:

(i) The inclusion of maternity coverage and the availability of riders for additional family members in student health care.

(ii) Family housing.

(iii) Child care.

(iv) Flexible or alternative academic scheduling, such as telecommuting programs, to enable pregnant or parenting students to continue their education or stay in school.

(v) Education to improve parenting skills for mothers and fathers and to strengthen marriages.

(vi) Maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children.

(vii) Post-partum counseling.

(C) Identify public and private service providers, located on the campus of the eligible institution or within the local community, that are qualified to meet the needs described in subparagraph (B), and establishes programs with qualified providers to meet such needs.

(D) Assist pregnant and parenting students, fathers or spouses in locating and obtaining services that meet the needs described in subparagraph (B).

(E) If appropriate, provide referrals for prenatal care and delivery, infant or foster care, or adoption, to a student who requests such information. An office shall make such referrals only to service providers that serve the following types of individuals:

(i) Parents.

(ii) Prospective parents awaiting adoption.

(iii) Women who are pregnant and plan on parenting or placing the child for adoption.

(iv) Parenting or prospective parenting couples.

(5) REPORTING.—

(A) ANNUAL REPORT BY INSTITUTIONS.—

(i) IN GENERAL.—For each fiscal year that an eligible institution of higher education receives funds under this subsection, the eligible institution shall prepare and submit to the State, by the date determined by the State, a report that—

(I) itemizes the pregnant and parenting student services office's expenditures for the fiscal year;

(II) contains a review and evaluation of the performance of the office in fulfilling the requirements of this section, using the specific performance criteria or standards established under subparagraph (B)(i); and

(III) describes the achievement of the office in meeting the needs listed in paragraph (4)(B) of the students served by the eligible institution, and the frequency of use of the office by such students.

(ii) PERFORMANCE CRITERIA.—Not later than 180 days before the date the annual report described in clause (i) is submitted, the State—

(I) shall identify the specific performance criteria or standards that shall be used to prepare the report; and

(II) may establish the form or format of the report.

(B) REPORT BY STATE.—The State shall annually prepare and submit a report on the findings under this subsection, including the number of eligible institutions of higher education that were awarded funds and the number of students served by each pregnant and parenting student services office receiving funds under this section, to the Secretary.

(c) SUPPORT FOR PREGNANT AND PARENTING TEENS.—A State may use amounts received under a grant under section __001 to make funding available to eligible high schools and community service centers to establish, maintain or operate pregnant and parenting services in the same general manner and in accordance with all conditions and requirements described in subsection (b), except that paragraph (3) of such subsection shall not apply for purposes of this subsection.

(d) IMPROVING SERVICES FOR PREGNANT WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIOLENCE, SEXUAL ASSAULT, AND STALKING.—

(1) IN GENERAL.—A State may use amounts received under a grant under section __001 to make funding available to its State Attorney General to assist Statewide offices in providing—

(A) intervention services, accompaniment, and supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking.

(B) technical assistance and training (as described in subsection (c)) relating to violence against eligible pregnant women to be made available to the following:

(i) Federal, State, tribal, territorial, and local governments, law enforcement agencies, and courts.

(ii) Professionals working in legal, social service, and health care settings.

(iii) Nonprofit organizations.

(iv) Faith-based organizations.

(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1), a State Attorney General shall submit an application to the designated State agency at such time, in such manner, and containing such information, as specified by the State.

(3) TECHNICAL ASSISTANCE AND TRAINING DESCRIBED.—For purposes of paragraph (1)(B), technical assistance and training is—

(A) the identification of eligible pregnant women experiencing domestic violence, sexual violence, sexual assault, or stalking;

(B) the assessment of the immediate and short-term safety of such a pregnant woman, the evaluation of the impact of the violence or stalking on the pregnant woman's health, and the assistance of the pregnant woman in developing a plan aimed at preventing further domestic violence, sexual violence, sexual assault, or stalking, as appropriate;

(C) the maintenance of complete medical or forensic records that include the documentation of any examination, treatment given, and referrals made, recording the location and nature of the pregnant woman's injuries, and the establishment of mechanisms to ensure the privacy and confidentiality of those medical records; and

(D) the identification and referral of the pregnant woman to appropriate public and private nonprofit entities that provide intervention services, accompaniment, and supportive social services.

(4) ELIGIBLE PREGNANT WOMAN.—In this subsection, the term ''eligible pregnant woman'' means any woman who is pregnant on the date on which such woman becomes a victim of domestic violence, sexual violence, sexual assault, or stalking or who was pregnant during the one-year period before such date.

(e) PUBLIC AWARENESS AND EDUCATION.—A State may use amounts received under a grant under section __001 to make funding available to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this title, or any other resources available to pregnant and parenting women in keeping with the intent and purposes of this title. The State shall be responsible for setting guidelines or limits as to how much of funding may be utilized for public awareness and education in any funding award.

SEC. __004. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated, $25,000,000 for each of fiscal years 2010 through 2019, to carry out this title.

SA 3099. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IX, insert the following:

Subtitle ___—Expansion of Adoption Credit and Adoption Assistance Programs

SEC. __01. EXPANSION OF ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

(a) INCREASE IN DOLLAR LIMITATION.—

(1) ADOPTION CREDIT.—

(A) IN GENERAL.—Paragraph (1) of section 23(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$15,000''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (3) of section 23(a) of such Code (relating to $10,000 credit for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$15,000'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$15,000''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (h) of section 23 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(h) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2009, each of the dollar amounts in subsections (a)(3) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A)(i) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(2) ADOPTION ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—Paragraph (1) of section 137(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$15,000''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (2) of section 137(a) of such Code (relating to $10,000 exclusion for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$15,000'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$15,000''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (f) of section 137 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(f) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2009, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(b) CREDIT MADE REFUNDABLE.—

(1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue Code of 1986 is amended—

(A) by redesignating section 23, as amended by subsection (a), as section 36B, and

(B) by moving section 36B (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(2) CONFORMING AMENDMENTS.—

(A) Section 24(b)(3)(B) of such Code is amended by striking ''23,''.

(B) Section 25(e)(1)(C) of such Code is amended by striking ''23,'' both places it appears.

(C) Section 25A(i)(5)(B) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(D) Section 25B(g)(2) of such Code is amended by striking ''23,''.

(E) Section 26(a)(1) of such Code is amended by striking ''23,''.

(F) Section 30(c)(2)(B)(ii) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(G) Section 30B(g)(2)(B)(ii) of such Code is amended by striking ''23,''.

(H) Section 30D(c)(2)(B)(ii) of such Code is amended by striking ''sections 23 and'' and inserting ''section''.

(I) Section 36B of such Code, as so redesignated, is amended—

(i) by striking paragraph (4) of subsection (b), and

(ii) by striking subsection (c).

(J) Section 137 of such Code is amended—

(i) by striking ''section 23(d)'' in subsection (d) and inserting ''section 36B(d)'', and

(ii) by striking ''section 23'' in subsection (e) and inserting ''section 36B''.

(K) Section 904(i) of such Code is amended by striking ''23,''.

(L) Section 1016(a)(26) is amended by striking ''23(g)'' and inserting ''36B(g)''.

(M) Section 1400C(d) of such Code is amended by striking ''23,''.

(N) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code of 1986 is amended by striking the item relating to section 23.

(O) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36B,'' after ''36A,''.

(P) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

''Sec. 36B. Adoption expenses.''.

(c) EXTENSION OF CREDIT AND ADOPTION ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986, as redesignated by subsection (b), is amended by adding at the end the following new subsection:

''(i) TERMINATION.—This section shall not apply to expenses paid or incurred in taxable years beginning after December 31, 2019.''.

(2) IN GENERAL.—Section 137 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) TERMINATION.—This section shall not apply to expenses paid or incurred in taxable years beginning after December 31, 2019.''.

(3) SUNSET FOR MODIFICATIONS MADE BY EGTRRA TO ADOPTION CREDIT REMOVED.—Title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 shall not apply to the amendments made by section 202 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3100. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 128, between lines 6 and 7, insert the following:

(e) EDUCATED HEALTH CARE CONSUMERS.—The term ''educated health care consumer'' means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

On page 142, line 15, insert ''educated'' before ''health care''.

On page 192, line 23, insert ''educated'' before ''health care''.

SA 3101. Mr. FRANKEN 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 692, between lines 14 and 15, insert the following:

SEC. 3009. RULE OF CONSTRUCTION.

Nothing in the provisions of, or amendments made by, this Act shall be construed as prohibiting the application of value-based purchasing reforms under the Medicare program under title XVIII of the Social Security Act under such provisions or amendments to items and services furnished to individuals eligible for benefits under the Medicare program as a result of any expansion of such eligibility under the provisions of, or amendments made by, this Act.

SA 3102. Mr. DURBIN (for himself 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 816, after line 20, insert the following:

SEC. 3115. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVISIONS.

(a) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting ''(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))'' before '', with the thirty-sixth month''.

(B) APPLICATION.—Section 1836 of such Act (42 U.S.C. 1395o) is amended—

(i) by striking ''Every individual who'' and inserting ''(a) IN GENERAL.—Every individual who''; and

(ii) by adding at the end the following new subsection:

''(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs by reason of section 226A(b)(2), the following rules shall apply:

''(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

''(B) The individual shall be responsible for providing for payment of the portion of the

premium under section 1839 which is not covered under the Medicare savings program (as defined in section 1144(c)(7)) in order to receive such coverage.

''(C) The provision of such drugs shall be subject to the application of—

''(i) the deductible under section 1833(b); and

''(ii) the coinsurance amount applicable for such drugs (as determined under this part).

''(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

''(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

''(A) identifying individuals that are entitled to coverage of immunosuppressive drugs by reason of section 226A(b)(2); and

''(B) distinguishing such individuals from individuals that are enrolled under this part for the complete package of benefits under this part.''.

(C) TECHNICAL AMENDMENT TO CORRECT DUPLICATE SUBSECTION DESIGNATION.—Subsection (c) of section 226A of such Act (42 U.S.C. 426–1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: ''With regard to immunosuppressive drugs furnished on or after the date of the enactment of the Patient Protection and Affordable Care Act, this subparagraph shall be applied without regard to any time limitation.''.

(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—Section 1881 of the Social Security Act is amended—

(1) in subsection (b)(14)(B)(iii), by inserting '', including oral drugs that are not the oral equivalent of an intravenous drug (such as oral phosphate binders and calcimimetics),'' after ''other drugs and biologicals'';

(2) in subsection (b)(14)(E)(ii)—

(A) in the first sentence—

(i) by striking ''a one-time election to be excluded from the phase-in'' and inserting ''an election, with respect to 2011, 2012, or 2013, to be excluded from the phase-in (or the remainder of the phase-in)''; and

(ii) by adding before the period at the end the following: ''for such year and for each subsequent year during the phase-in described in clause (i)''; and

(B) in the second sentence—

(i) by striking ''January 1, 2011'' and inserting ''the first date of such year''; and

(ii) by inserting ''and at a time'' after ''form and manner''; and

(3) in subsection (h)(4)(E), by striking ''lesser'' and inserting ''greater''.

SA 3103. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. MANDATORY REPORTING OF FRAUD BY MEDICARE ADVANTAGE PLANS, PRESCRIPTION DRUG PLANS, AND PROVIDERS OF SERVICES AND SUPPLIERS.

(a) MANDATORY REPORTING BY MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(7) REPORTING OF PROBABLE FRAUD.—

''(A) IN GENERAL.—Each Medicare Advantage organization and, in accordance with section 1860D–12(b)(3)(C), each PDP sponsor of a prescription drug plan shall, in accordance with regulations established by the Secretary under subparagraph (B)—

''(i) self-report to the Secretary and to the appropriate law enforcement or oversight agency any matter for which the organization or sponsor has liability and for which the organization or sponsor has identified, from any source, credible evidence of fraud related to the program under this part or part D; and

''(ii) report to the Secretary and to the appropriate law enforcement or oversight agency any matter for which the organization or sponsor has identified, from any source, credible evidence of fraud by subcontractors or others related to the program under this part or part D.

''(B) REGULATIONS.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish regulations to carry out this paragraph.''.

(b) MANDATORY REPORTING BY PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1866(j)(7)(B) of the Social Security Act, as inserted by section 6401, is amended by adding at the end the following sentence: ''Such core elements shall include, to the extent determined appropriate by the Secretary, internal monitoring and auditing of, and responding to, identified deficiencies. Such response shall include reporting to the Secretary and to the appropriate law enforcement or oversight agency credible evidence of fraud related to the program under this title, title XIX, or title XXI.''.

(c) PROMPT AND APPROPRIATE ACTION BY THE SECRETARY.—The Secretary shall take prompt and appropriate action to forward information on fraud reported under sections 1857(d)(7) and 1866(j)(7)(B) of the Social Security Act, as added by subsection (a) and amended by subsection (b), respectively, to the appropriate agencies.

(d) ANNUAL REPORT TO CONGRESS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress an annual report on actions taken by the Secretary to address fraud during the preceding year. The report shall include an analysis of trends and conditions giving rise to fraud and general actions taken to address such trends and conditions, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SA 3104. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 426, line 14, insert '', in cases where eligibility for medical assistance under this title is not established pursuant to otherwise applicable procedures under the Patient Protection and Affordable Care Act, including section 1413 of such Act,'' after ''shall not''.

SA 3105. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1395, strike line 11 and all that follows through ''**SEC. 778.**'' on line 15 and insert the following:

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317G the following:

''SEC. 317G–1.

SA 3106. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 301, after line 25, add the following:

SEC. 1413A. ASSURANCE OF EFFECTIVE IMPLEMENTATION OF STREAMLINED ENROLLMENT PROCEDURES.

(a) AMENDMENTS TO SECTION 1413.—Section 1413 of this Act is amended—

(1) in subsection (a), by striking the second sentence and inserting ''Such system shall ensure that if an individual applying to an Exchange, to a State Medicaid program under title XIX of the Social Security Act, or to a State children's health insurance program (CHIP) under title XXI of such Act, is found to be ineligible for the program to which the individual applied, the individual shall be screened for eligibility for all other potentially applicable such programs and shall be enrolled in the program for which the individual qualifies.'';

(2) in subsection (b)(1), by adding at the end the following:

''(D) RELEVANCE.—The forms described in subparagraphs (A) and (B) shall not require the applicant to answer any questions that are irrelevant to establishing eligibility for applicable State health subsidy programs. The Secretary shall establish procedures that avoid any need for such requirements, which shall include determining the amounts expended for medical assistance that are described in subsection (y)(1) of section 1905 of the Social Security Act (as added by section 2001(a)(3) of this Act) through the use of the post-enrollment procedures described in section 1903(u)(1)(C) of the Social Security Act.'';

(3) in subsection (c)(2)(B)(ii)(II), by striking ''by requesting'' and inserting ''notwithstanding section 1411(b), by requesting'';

(4) in subsection (c)(2)(C), by inserting ''is'' before ''consistent''; and

(5) in subsection (e)(1), by striking ''enrollment in qualified health plans offered through an Exchange, including the'' and inserting ''determination of eligibility for''.

(b) AMENDMENT TO SOCIAL SECURITY ACT.—Subparagraph (H) of section 1902(e)(14) of the Social Security Act (as added by section 2002 of this Act), is amended, in the matter preceding clause (i), by striking ''shall not be construed'' and inserting ''shall not, in cases where eligibility for medical assistance under this title is not established pursuant to otherwise applicable procedures under the Patient Protection and Affordable Care Act, including section 1413 of such Act, be construed''.

SA 3107. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1413 and insert the following:

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange, to a State Medicaid program under title XIX of the Social Security Act, or to a State children's health insurance program (CHIP) under title XXI of such Act, is found to be ineligible for the program to which the individual applied, the individual shall be screened for eligibility for all other potentially applicable such programs and shall be enrolled in the program for which the individual qualifies.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(D) RELEVANCE.—The forms described in subparagraphs (A) and (B) shall not require the applicant to answer any questions that are irrelevant to establishing eligibility for applicable State health subsidy programs. The Secretary shall establish procedures that avoid any need for such requirements, which shall include determining the amounts expended for medical assistance that are described in subsection (y)(1) of section 1905 of the Social Security Act (as added by section 2001(a)(3) of this Act) through the use of the post-enrollment procedures described in section 1903(u)(1)(C) of the Social Security Act.

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) notwithstanding section 1411(b), by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) is consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

(3) DETERMINATION OF ELIGIBILITY.—

(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ''applicable State health subsidy program'' means—

(1) the program under this title for the determination of eligibility for premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SA 3108. Ms. COLLINS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. IMPROVING CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended—

(1) by inserting ''(as those terms are defined in section 1861(aa)(5))'' after ''clinical nurse specialist''; and

(2) by inserting '', or in the case of services described in subparagraph (C), a physician, or a nurse practitioner or clinical nurse specialist who is working in collaboration with a physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of a physician'' after ''collaboration with a physician''.

(b) CONFORMING AMENDMENTS.—(1) Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)), as amended by section 3108(a)(2) and section 6407, is amended—

(A) in paragraph (2)(C), by inserting '', a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant (as the case may be)'' after ''physician'' each place it appears;

(B) in the second sentence, by inserting ''certified nurse-midwife,'' after ''clinical nurse specialist,'';

(C) in the third sentence—

(i) by striking ''physician certification'' and inserting ''certification'';

(ii) by inserting ''(or on January 1, 2008, in the case of regulations to implement the amendments made by section 3115 of the Patient Protection and Affordable Care Act)'' after ''1981''; and

(iii) by striking ''a physician who'' and inserting ''a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant who''; and

(D) in the fourth sentence, by inserting '', nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant'' after ''physician''.

(2) Section 1835(a) of the Social Security Act (42 U.S.C. 1395n(a)), as amended by section 6405, is amended—

(A) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ''or an eligible professional under section 1848(k)(3)(B)'' and inserting '', an eligible professional under section 1848(k)(3)(B), or a nurse practitioner or clinical nurse specialist (as those terms are defined in 1861(aa)(5)) who is working in collaboration with a physician enrolled under section 1866(j) or such an eligible professional in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of a physician so enrolled or such an eligible professional''; and

(ii) in each of clauses (ii) and (iii) of subparagraph (A) by inserting '', a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant (as the case may be)'' after ''physician'';

(B) in the third sentence, by inserting '', nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant (as the case may be)'' after physician;

(C) in the fourth sentence—

(i) by striking ''physician certification'' and inserting ''certification'';

(ii) by inserting ''(or on January 1, 2008, in the case of regulations to implement the amendments made by section 3115 of the Patient Protection and Affordable Care Act)'' after ''1981''; and

(iii) by striking ''a physician who'' and inserting ''a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant who''; and

(D) in the fifth sentence, by inserting '', nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant'' after ''physician''.

(3) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in subsection (m)—

(i) in the matter preceding paragraph (1)—

(I) by inserting ''a nurse practitioner or a clinical nurse specialist (as those terms are defined in subsection (aa)(5)), a certified nurse-midwife (as defined in section 1861(gg)), or a physician assistant (as defined in subsection (aa)(5))'' after ''physician'' the first place it appears; and

(II) by inserting ''a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant'' after ''physician'' the second place it appears; and

(ii) in paragraph (3), by inserting ''a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant'' after ''physician''; and

(B) in subsection (o)(2)—

(i) by inserting '', nurse practitioners or clinical nurse specialists (as those terms are defined in subsection (aa)(5)), certified nurse-midwives (as defined in section 1861(gg)), or physician assistants (as defined in subsection (aa)(5))'' after ''physicians''; and

(ii) by inserting '', nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant,'' after ''physician''.

(4) Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended—

(A) in subsection (c)(1), by inserting '', the nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)), the certified nurse-midwife (as defined in section 1861(gg)), or the physician assistant (as defined in section 1861(aa)(5)),'' after ''physician''; and

(B) in subsection (e)—

(i) in paragraph (1)(A), by inserting '', a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)), a certified nurse-midwife (as defined in section 1861(gg)), or a physician assistant (as defined in section 1861(aa)(5))'' after ''physician''; and

(ii) in paragraph (2)—

(I) in the heading, by striking ''PHYSICIAN CERTIFICATION'' and inserting ''RULE OF CONSTRUCTION REGARDING REQUIREMENT FOR CERTIFICATION''; and

(II) by striking ''physician''.

(c) REQUIREMENT OF FACE-TO-FACE ENCOUNTER.—

(1) PART A.—Section 1814(a)(2)(C) of the Social Security Act, as amended by subsection (b) and section 6407(a), is further amended by striking '', and, in the case of a certification made by a physician'' and all that follows through ''face-to-face encounter'' and inserting '', and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant (as the case may be), prior to making such certification the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant must document that the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant himself or herself has had a face-to-face encounter''.

(2) PART B.—Section 1835(a)(2)(A)(iv) of the Social Security Act, as added by section 6407(a), is amended by striking ''after January 1, 2010'' and all that follows through ''face-to-face encounter'' and inserting ''made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant (as the case may be), prior to making such certification the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant must document that the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant has had a face-to-face encounter''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2010.

SA 3109. Mr. AKAKA 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 974, between lines 9 and 10, insert the following:

SEC. 3316. PHARMACY ACCESS FOR CHRONIC CARE TARGETED INDIVIDUALS.

(a) PURPOSE.—The purpose of this section is to provide for the establishment of chronic care pharmacy programs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act that utilize available technologies and efficiencies to improve the safety, convenience, and affordability of prescription drug coverage under such part with respect to long-term maintenance medication refills for enrollees with a chronic disease or condition.

(b) ESTABLISHMENT AND IMPLEMENTATION OF PROGRAM.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(m) PHARMACY ACCESS FOR TARGETED BENEFICIARIES.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT AND IMPLEMENTATION OF PROGRAM.—The PDP sponsor of a prescription drug plan shall—

''(i) identify (not less frequently than on a quarterly basis) targeted beneficiaries who are enrolled in the prescription drug plan; and

''(ii) establish and maintain a chronic care pharmacy program that meets the requirements of this subsection.

''(B) DEFINITIONS.—In this subsection:

''(i) CHRONIC CARE PHARMACY PROGRAM.—The term 'chronic care pharmacy program' means the program established and maintained by a PDP sponsor under subparagraph (A)(ii).

''(ii) TARGETED BENEFICIARY.—The term 'targeted beneficiary' means a part D eligible individual who is identified by the PDP sponsor as taking at least 1 long-term maintenance medication.

''(iii) LONG-TERM MAINTENANCE MEDICATION.—The term 'long-term maintenance medication' means a covered part D drug that—

''(I) has a common indication (obtained from product labeling) for the treatment of a chronic disease or condition; and

''(II) is used for the treatment of a chronic disease or condition when the duration of continuous therapy can reasonably be expected to exceed 1 year.

''(2) ENROLLMENT.—

''(A) AUTOMATIC ENROLLMENT.—The PDP sponsor shall automatically enroll targeted beneficiaries identified under paragraph (1)(A)(i) in a chronic care pharmacy program.

''(B) WRITTEN NOTICE AND PROCESS TO OPT OUT OF PROGRAM.—

''(i) WRITTEN NOTICE.—The PDP sponsor shall provide written notice to targeted beneficiaries automatically enrolled in the chronic care pharmacy program under subparagraph (A).

''(ii) PROCESS TO DECLINE ENROLLMENT AND OPT OUT OF PROGRAM.—The written notice provided under clause (i) shall include procedures under which the targeted beneficiary may decline such automatic enrollment and opt-out of the chronic care pharmacy program.

''(3) CHRONIC CARE PHARMACY PROGRAM REQUIREMENTS.—The PDP sponsor shall establish and maintain procedures to ensure that each of the following requirements is met by a chronic care pharmacy program:

''(A) A targeted beneficiary is (not less frequently than on an annual basis) provided a claims-based comprehensive written summary of the targeted beneficiary's drug therapy that includes an analysis of—

''(i) poly-pharmacy and other safety issues, including the identification of duplicative or excessive drug therapy in order to reduce

harmful adverse drug reactions and unnecessary hospitalizations; and

''(ii) clinically appropriate alternative formulary treatment options and lower cost alternatives, if any, for consideration by the treating physician of the targeted beneficiary.

''(B) Any chronic care pharmacy under the program is accredited by a private accrediting organization as meeting standards appropriate for pharmacies that dispense long-term maintenance medications, including a process for quality and safety improvement.

''(C) The program makes available, 24 hours a day, 7 days a week, to a targeted beneficiary confidential pharmacist counseling, based on the targeted beneficiary's drug therapy.

''(D) The program delivers to the address specified by the targeted beneficiary an extended supply (such as 90-days) of long-term maintenance medications where permitted by law and when indicated to be clinically appropriate.

''(E) The program provides, after filling a prescription for a targeted beneficiary for 2 consecutive months, only an extended supply of a long-term maintenance medication, except that a 1-time 30-day supply of such a medication may be provided to the targeted beneficiary at a retail pharmacy in order to transition a targeted beneficiary into the program.

''(4) ACCESS TO COVERED PART D DRUGS.—The requirements of subsection (b)(1) shall apply to a chronic care pharmacy program, except that the requirements of subparagraphs (A) and (D) of such subsection shall apply only in the case of an individual who opts out of the chronic care pharmacy program under paragraph (2)(A)(ii).

''(5) FACILITATING AFFORDABLE PAYMENT ARRANGEMENTS.—With respect to an extended supply of part D covered drugs for a targeted beneficiary under the chronic care pharmacy program, the PDP sponsor shall offer to the targeted beneficiary an option to arrange for the payment of any required cost-sharing by a targeted beneficiary on an alternative basis (including more affordable payments in installments) over the period of the extended supply.

''(6) CONTINUITY OF ELECTION.—In the case where a targeted beneficiary changes enrollment to a different prescription drug plan (including a prescription drug plan offered by a different sponsor)—

''(A) the PDP sponsor of the plan from which the targeted beneficiary disenrolls shall notify the Secretary (as part of the disenrollment process)—

''(i) that the individual is a targeted beneficiary to whom the requirements of this subsection apply; and

''(ii) whether the targeted beneficiary elected to opt out of the chronic care pharmacy program under paragraph (2)(A)(ii); and

''(B) the Secretary shall ensure that, in the case where the targeted beneficiary has not elected to opt out as described in subparagraph (A)(ii), the continuation of the enrollment of the targeted beneficiary in the chronic care pharmacy program of the PDP sponsor offering the prescription drug plan in which the targeted beneficiary has enrolled.

''(7) PROVIDING INFORMATION TO BENEFICIARIES.—The Secretary shall include information regarding chronic care pharmacy programs in the activities required under section 1860D–1(c) (relating to the provision of information to beneficiaries with respect to informed choice, and other information), including any consumer satisfaction surveys under subsection (d).

''(8) EXCEPTION FOR LONG-TERM CARE FACILITIES.—This subsection shall not apply to a long-term care facility or a pharmacy located in, or having a contract with, a long-term care facility.''.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply for contract years beginning with 2011.

SA 3110. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

SEC. 3316. PERFORMANCE BASED PHARMACY REIMBURSEMENT PROGRAM.

(a) IN GENERAL.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(m) PERFORMANCE BASED PHARMACY REIMBURSEMENT PROGRAM.—

''(1) IN GENERAL.—The PDP sponsor shall have in place a program that identifies omission gaps and adherence gaps (as defined in paragraph (2)) for specified beneficiaries (as described in paragraph (3)) and makes payments to participating pharmacies (as described in paragraph (4)) that close such gaps through clinical counseling.

''(2) OMISSION AND ADHERENCE GAPS DEFINED.—In this subsection:

''(A) OMISSION GAPS.—The term 'omission gaps' refers to cases when the patient is not receiving a medication that evidenced-based protocols or clinical practice standards indicate is a best practice for treatment of their disease.

''(B) ADHERENCE GAPS.—The term 'adherence gaps' refers to cases when a patient is not taking their medication the way it was prescribed, including failure to fill, failure to renew, stopping or not starting medications, or not taking a medication the way it was intended.

''(3) SPECIFIED BENEFICIARIES DESCRIBED.—Beneficiaries described in this paragraph are part D eligible individuals taking medications for one of the following conditions:

''(A) Diabetes.

''(B) Cardiovascular disease.

''(C) Pulmonary disease.

''(4) PARTICIPATING PHARMACIES.—The PDP sponsor shall contract with any pharmacy that is willing to participate in such program and meet the standard terms and conditions of the PDP sponsor. To the extent practicable, the PDP sponsor shall use a specified beneficiary's primary pharmacy to close gaps in care. If such pharmacy does not participate in such program or is unable to close a gap in care, the PDP sponsor may use other participating pharmacies. The primary pharmacy selected by the PDP sponsor shall advise the specified beneficiary of his or her right to select another participating pharmacy.

''(5) GAPS IN MEDICATION ADHERENCE.—The Secretary shall require PDP sponsors to follow uniform standards in identifying gaps in medication adherence. The Secretary shall develop such standards based on current treatment protocols for the conditions described in paragraph (2).

''(6) PAYMENTS TO PDP SPONSORS.—

''(A) IN GENERAL.—The Secretary shall pay each PDP sponsor a per member monthly amount to administer such program. Such payments shall be for operational and administrative activities only and shall not include the cost of any covered part D drug. The per member monthly payment to a PDP sponsor may not exceed an amount that equals $0.85 in 2012, increased in subsequent years by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of the previous year.

''(B) SPECIAL RULE.—The Secretary shall ensure that PDP sponsors use greater than 50 percent of the aggregate amount paid to the PDP sponsor under subparagraph (A) to compensate pharmacies for counseling activities under such program.

''(C) NOT IN BIDS.—PDP sponsors shall not include the payments described in subparagraph (A) in the bids submitted by the PDP sponsor under section 1860D–11.

''(D) SOURCE.—The payment described in subparagraph (A) shall be made from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate.

''(7) PAYMENTS TO PARTICIPATING PHARMACIES FROM PDP SPONSORS.—Under such program, PDP sponsors shall negotiate payment structures with pharmacies, and pharmacists shall receive remuneration based on success in closings gaps in care. Payments under paragraph (6)(A) shall be made when it is determined that the adherence and omission gaps have been closed, or when billable activity by the pharmacy occurs, by contract.

''(8) BONUSES AND PENALTIES FOR PDP SPONSORS BASED ON ESTIMATED CHANGES IN MEDICAL COSTS.—

''(A) PROJECTED COSTS.—Beginning in 2012, the Secretary shall, on an annual basis, project the anticipated costs for individuals enrolled in the program under parts A and B for the current year and the succeeding 2 years, based on risk-adjusted historical costs under such parts.

''(B) COMPARISON.—

''(i) IN GENERAL.—At the end of each 3-year period described in subparagraph (A), for each PDP sponsor under the program, the Secretary shall compare the actual spending for such individuals to the costs projected under subparagraph (A).

''(ii) INCENTIVE PAYMENT.—For each year during the 3-year period described in clause (i), to the extent the actual costs are lower than the costs projected under subparagraph (A), the Secretary will pay to the PDP sponsor an incentive based on a graduated scale, under which the PDP sponsor receives an incremental 10 percent of the per member monthly amount paid to the PDP sponsor under paragraph (6) for every 10 percent of savings above the projection, not to exceed 50 percent of the aggregate amounts paid to the PDP sponsor under such paragraph for the initial year of the 3-year period.

''(iii) PENALTIES.—For each year during the 3-year period described in clause (i), to the extent the actual costs are higher than the costs projected under subparagraph (A), the PDP sponsor shall make a payment to the Secretary in an amount based on a graduated scale, under which the PDP sponsor pays to the Secretary 10 percent of the per member monthly amount paid to the PDP sponsor under paragraph (6) for every 10 percent of costs above the projection, not to exceed 50 percent of the aggregate amounts paid to the PDP sponsor under such paragraph for the initial year of the 3-year period.

''(C) GUIDANCE ON METHODOLOGY USED.—The Secretary shall issue guidance on the methodology that the Secretary uses to project costs as described in subparagraph (A), measure actual costs for purposes of the comparison under subparagraph (B), and calculate

incentive payment and penalties under clauses (ii) and (iii), respectively, of such subparagraph.

''(D) PHARMACIES NOT LIABLE FOR FEES.—A participating pharmacy shall not be required to pay any penalties under subparagraph (B)(iii).

''(E) RECONCILIATION.—Any financial reconciliation under the program under this subsection shall be incorporated into the annual reconciliation process under this part.

''(9) LIMITATION.—The requirements of this subsection shall not apply to an MA–PD plan.

''(10) CONSTRUCTION.—The provisions of this subsection shall not modify or relieve PDP sponsors of their responsibilities under subsection (c)(2).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2012.

SA 3111. Mr. SESSIONS 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 245, beginning with line 15, strike all through page 246, line 7.

On page 254, strike lines 11 through 20.

On page 260, strike lines 14 through 17.

On page 267, strike lines 17 through 25.

On page 268, between lines 13 and 14, insert the following:

(3) SUBSIDIES TREATED AS PUBLIC BENEFIT.—Notwithstanding any other provision of this Act or any other provision of law, for purposes of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613), the following shall be considered a Federal means-tested public benefit:

(A) The ability of an individual to purchase a qualified health plan offered through an Exchange.

(B) The premium tax credit established under section 1401 of this Act (and any advance payment thereof).

(C) The cost sharing reductions established under this section (and any advance payment thereof).

On page 269, strike lines 7 through 9, and insert the following:

(a) VERIFICATION PROCESS.—The Secretary shall ensure that eligibility determinations required by this Act are conducted in accordance with the following requirements, including requirements for determining:

On page 269, line 18, insert ''eligible'' before ''alien''.

On page 270, line 16, strike ''provide'' and insert ''appear in person to provide the Exchange with the following''.

On page 270, between lines 20 and 21, insert the following:

(B) A sworn statement, under penalty of perjury, specifically attesting to the fact that each enrollee is either a citizen or national of the United States or an eligible lawful permanent resident meeting the requirements of section 1402(f)(3) of this Act and identifying the applicable eligibility status for each enrollee; and

On page 270, line 21, insert ''and documentation'' after ''information''.

On page 271, strike lines 4 through 15, and insert the following:

(A) In the case of an enrollee whose eligibility is based on attestation of citizenship of the enrollee, the enrollee shall provide satisfactory evidence of citizenship or nationality (within the meaning of section 1903(x) of the Social Security Act (42 U.S.C. 1396b)).

(B) In the case of an individual whose eligibility is based on attestation of the enrollee's immigration status—

(i) such information as is necessary for the individual to demonstrate they are in ''satisfactory immigration status'' as defined and in accordance with the Systematic Alien Verification for Entitlements (SAVE) program established by section 1137 of the Social Security Act (42 U.S.C. 1320b–7), and

(ii) any other additional identifying information as the Secretary, in consultation with the Secretary of Homeland Security, may require in order for the enrollee to demonstrate satisfactory immigration status.

On page 274, beginning with line 12, strike all through page 276, line 17, and insert the following:

(c) VERIFICATION OF ELIGIBILITY THROUGH DOCUMENTATION.—

(1) IN GENERAL.—Each Exchange shall conduct eligibility verification, using the information provided by an applicant under subsection (b), in accordance with this subsection.

(2) VERIFICATION OF CITIZENSHIP OR IMMIGRATION STATUS.—

(A) VERIFICATION OF ATTESTATION OF CITIZENSHIP.—Each Exchange shall verify the eligibility of each enrollee who attests that they are a citizen or national of the United States, as required by subsection (b)(1)(A) of this section, in accordance with the provisions of section 1903(x) of the Social Security Act.

(B) VERIFICATION OF ATTESTATION OF ELIGIBLE IMMIGRATION STATUS.—Each Exchange shall verify the eligibility of each enrollee who attests that they are eligible to participate in the exchange by virtue of having been a lawful permanent resident for not less than 5 years, as required by subsection (b)(1)(B) of this section, in accordance with the provisions of section 1137 of the Social Security Act.

On page 277, beginning with line 19, strike all through page 278, line 16.

On page 280, strike lines 8 and 9 and insert ''in accordance with the secondary verification process established consistent with section 1137 of the Social Security Act (as is in effect as of January 1, 2009).''

SA 3112. Ms. CANTWELL (for herself, Ms. SNOWE, Ms. LANDRIEU, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 354, between lines 18 and 19, insert the following:

(B) CERTAIN EMPLOYEES TREATED AS FULL-TIME.—Solely for purposes of applying subsections (a) and (c), an employee not otherwise treated as a full-time employee under subparagraph (A) shall be treated as a full-time employee if the employee is employed at least 390 hours of service per calendar quarter.

SA 3113. Mr. SPECTER 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 869, between lines 14 and 15, insert the following:

SEC. 3143. REVISION TO PAYMENT FOR CONSULTATION CODES.

(a) TEMPORARY DELAY OF ELIMINATION OF PAYMENT FOR CONSULTATION CODES.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to January 1, 2011, implement a final rule relating payment policies under the physician fee schedule and part B of title XVIII of the Social Security Act that contains a provision that eliminates or discontinues payment for consultation codes.

(b) EVALUATION PERIOD.—During the period prior to January 1, 2011, the Secretary of Health and Human Services shall consult with the Current Procedural Terminology Editorial Panel of the American Medical Association for the purpose of developing proposals to—

(1) modify existing consultation codes or establish new consultation codes to more accurately reflect the value provided through such consultation services; and

(2) minimize coding errors.

SA 3114. Mr. GRASSLEY (for himself, Mr. COBURN, Mr. BROWNBACK, Mr. CHAMBLISS, Mr. ISAKSON, Ms. MURKOWSKI, Mr. BUNNING, Mr. BENNETT, Mr. LEMIEUX, Mr. BARRASSO, and Mr. ENZI) 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 30, between lines 2 and 3, insert the following:

''(c) PROTECTION OF SECOND AMENDMENT RIGHTS.—

''(1) FINDING.—Congress finds that the second amendment to the Constitution of the United States protects a fundamental right for individuals, including those who are not members of a militia or engaged in military service or training, to keep and bear arms.

''(2) WELLNESS AND PREVENTION PROGRAMS.—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

''(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

''(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

''(3) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

''(A) the lawful ownership or possession of a firearm or ammunition;

''(B) the lawful use of a firearm or ammunition; or

''(C) the lawful storage of a firearm or ammunition.

''(4) LIMITATION ON DATABASES OR DATA BANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

''(5) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

''(A) the lawful ownership or possession of a firearm or ammunition; or

''(B) the lawful use or storage of a firearm or ammunition.

''(6) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

''(A) the lawful ownership or possession of a firearm or ammunition; or

''(B) the lawful use, possession, or storage of a firearm or ammunition.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON FINANCE

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on December 9, 2009, at 2:30 p.m., in room 215 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Exports' Place on the Path of Economic Recovery.''

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

COMMITTEE ON FOREIGN RELATIONS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 9, 2009, at 10 a.m., to hold a hearing entitled ''The New Afghanistan Strategy: The View from the Ground.''

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

COMMITTEE ON FOREIGN RELATIONS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 9, 2009, at 2:30 p.m., to hold a hearing entitled ''Strengthening the Transatlantic Economy: Moving Beyond the Crisis.''

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 9, 2009, at 10 a.m., to conduct a hearing entitled ''Five Years After the Intelligence Reform and Terrorism Prevention Act (IRTPA): Stopping Terrorist Travel.''

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

COMMITTEE ON INDIAN AFFAIRS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on December 9, 2009, at 9:30 a.m., in room 628 of the Dirksen Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on December 9, 2009, at 10 a.m., in room SH–216 of the Hart Senate Office Building, to conduct a hearing entitled ''Oversight of the Department of Homeland Security.''

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

COMMITTEE ON THE JUDICIARY

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on December 9, 2009, at 2 p.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Mortgage Fraud, Securities Fraud, and the Financial Meltdown: Prosecuting Those Responsible.''

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

COMMITTEE ON VETERANS' AFFAIRS

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on December 9, 2009. The Committee will meet in room 418 of the Russell Senate Office Building at 9:30 a.m.

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

SUBCOMMITTEE ON ECONOMIC POLICY

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs, Subcommittee on Economic Policy, be authorized to meet during the session of the Senate on December 9, 2009, at 2 p.m., to conduct a hearing entitled ''Weathering the Storm: Creating Jobs in the Recession.''

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

SUBCOMMITTEE ON SCIENCE AND SPACE

Ms. STABENOW. Mr. President, I ask unanimous consent that the Subcommittee on Science and Space of the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 9, 2009, at 2:30 p.m. in room 253 of the Russell Senate Office Building.

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

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs' Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia be authorized to meet during the session of the Senate on December 9, 2009, at 2:30 p.m. to conduct a hearing entitled, ''The Diplomat's Shield: Diplomatic Security in Today's World.''

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

ORDERS FOR THURSDAY, DECEMBER 10, 2009

Mr. BAUCUS. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Thursday, December 10; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation; that following leader remarks, the time until 1 p.m. be for debate only and equally divided, with the time until 11 a.m. controlled between the two leaders or their designees, with the remaining time until 1 p.m. controlled in alternating 30-minute blocks of time, with the majority controlling the first block and the Republicans controlling the next block.

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

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. BAUCUS. 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 7:19 p.m., adjourned until Thursday, December 10, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF ENERGY

PATRICIA A. HOFFMAN, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF ENERGY (ELECTRICITY DELIVERY AND ENERGY RELIABILITY), VICE KEVIN M. KOLEVAR, RESIGNED.

OFFICE OF THE FEDERAL COORDINATOR FOR ALASKA NATURAL GAS TRANSPORTATION PROJECTS

LARRY PERSILY, OF ALASKA, TO BE FEDERAL COORDINATOR FOR ALASKA NATURAL GAS TRANSPORTATION PROJECTS FOR THE TERM PRESCRIBED BY LAW, VICE DRUE PEARCE, RESIGNED.

DEPARTMENT OF STATE

MARI CARMEN APONTE, OF THE DISTRICT OF COLUMBIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF EL SALVADOR.

DONALD E. BOOTH, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

SUBJECT TO QUALIFICATIONS PROVIDED BY LAW, THE FOLLOWING FOR PERMANENT APPOINTMENT TO THE GRADES INDICATED IN THE NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION:

To be lieutenant

KEITH E. TUCKER

To be ensign

BRETT E. FLOYD
BRANDY E. GEIGER
ANTHONY J.M. IMBERI
BRIAN R.C. KENNEDY
ROBERT J. MITCHELL
LINH K. NGUYEN
ALISE N. PARRISH
AMBER M. PAYNE
ADAM C. PFUNDT
TAMERA J. REUL
KELLY M. SCHILL
MICHAEL S. SILAGI
TANNER A. SIMS
DAVID O. VEJAR
JASON P.R. WILSON

IN THE COAST GUARD

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT AS A PERMANENT COMMISSIONED OFFICER IN THE UNITED STATES COAST GUARD IN THE GRADE INDICATED UNDER TITLE 14, U.S.C, SECTION 211(A):

To be lieutenant

ROBERT A. MOOMAW

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIG. GEN. CAROL A. LEE

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIGADIER GENERAL ERIC W. CRABTREE
BRIGADIER GENERAL WALLACE W. FARRIS, JR.
BRIGADIER GENERAL CRAIG N. GOURLEY
BRIGADIER GENERAL DAVID S. POST
BRIGADIER GENERAL DONALD C. RALPH
BRIGADIER GENERAL JON R. SHASTEEN
BRIGADIER GENERAL RICHARD A. SHOOK, JR.
BRIGADIER GENERAL JAMES N. STEWART
BRIGADIER GENERAL LANCE D. UNDHJEM

IN THE ARMY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY JUDGE ADVOCATE GENERAL'S CORPS UNDER TITLE 10, U.S.C., SECTIONS 624 AND 3064:

To be colonel

JAMES R. AGAR II
JANE E. BAGWELL
RANDALL J. BAGWELL
MICHAEL R. BLACK
JOHN P. CARRELL
DAVID K. DALITION
THERESA A. GALLAGHER
TYLER J. HARDER
FRANCIS P. KING
KARL W. KUHN
MICHAEL O. LACEY
MARK D. MAXWELL
THOMAS C. MODESZTO
FRANKLIN D. RAAB
JAMES H. ROBINETTE II
PAUL T. SALUSSOLIA
RALPH J. TREMAGLIO III
STEVEN B. WEIR
KERRY M. WHEELEHAN

WITHDRAWAL

Executive Message transmitted by the President to the Senate on December 9, 2009 withdrawing from further Senate consideration the following nomination:

COAST GUARD NOMINATION OF RICHARD A. MOOMAW, TO BE LIEUTENANT, WHICH WAS SENT TO THE SENATE ON NOVEMBER 16, 2009.